

# International Journal of Mental Health and Capacity Law

## Articles

The Emotional Landscape of Money Management and Cognitive Decline: A  
Therapeutic Jurisprudence Perspective

'It's a Very Complex Thing': Discourse About Capacity in Australia's Northern  
Territory

Reforming the Fitness to be Tried Procedure in Ireland to Comply with the  
Convention on the Rights of Persons with Disabilities



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The International Journal of Mental Health and Capacity Law is a peer reviewed open access journal devoted to the intersection between law, mental health and mental capacity. It builds on the well-reputed Journal of Mental Health Law, with a revised name to reflect its wider focus. It also follows the desire of its predecessor to combine academic articles and commentary with material that is designed to be used by practitioners – lawyers, and medical or social work professionals – in these nuanced areas.

The Editors are keen to receive academic articles, both shorter ones of around 5000 words and longer ones of up to 12,000 words; and practice points, case notes and reports of research of around 5000 words. Submissions should be made via the Journal's website - <http://journals.northumbria.ac.uk/index.php/IJMHMCL/index> - and comply with the directions given there as to process. Manuscripts should comply either with the Oxford University Standard for Citation of Legal Authorities (<http://www.law.ox.ac.uk/publications/oscola.php>) or the APA Referencing Style Guide. If you use footnotes, we encourage short footnotes.

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All submissions will be peer-reviewed by a double blind peer review process before being accepted for publication; naturally, there will be a process whereby an article may be accepted subject to minor or more major amendments being made. We will endeavour to provide feedback as to why any rejected submission has been rejected.

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## EDITORIAL

The articles in this issue of the International Journal of Mental Health and Capacity Law continues our aim of highlighting the interplay between law, mental health and mental capacity in a variety of settings, both in terms of topics and jurisdictions of focus. Each of them also brings value beyond their immediate focus.

In the opening article, Professor Nicola Glover-Thomas discusses the potential role of therapeutic jurisprudence in securing better outcomes for older adults whose cognitive decline poses questions about capacity to manage financial affairs and which also implicates personal autonomy and well-being. Whilst this has a focus on the regulation of capacity in England and Wales, it looks at the broader implications of this, including well-being, and introduces the framework of therapeutic jurisprudence – the idea that, as interactions with legal processes have impacts on people, care should be taken in the design of those processes. Naturally, the aim of this consideration should be to seek a therapeutic/positive impact.

The next article, by Hannah Quadrio, takes us to the Northern Territory of Australia and investigates the value of providing a definition of capacity when that is used in mental health law, based on data from a small research study and placed in the context of a review of the legislative framework there. As part of this, she provides a useful summary of recent legislative developments in Australia, setting out the approach that has been taken to capacity in those changes.

We then move into the criminal jurisdiction and to Ireland for Luke Noonan's analysis of what the Convention on the Rights of Persons with Disabilities (CRPD) requires in relation to fitness to stand trial and how Irish law should be amended to be compliant with the requirements of the Convention. This provides guidance that can be used in other jurisdictions, given that the Committee on the Rights of Persons with Disabilities has been clear in its view that such processes are problematic. On this see, *Noble v Australia*,<sup>2</sup> which Noonan discusses; another example is *Medina Vela v Mexico*,<sup>3</sup> showing that this is not limited to common law jurisdictions.

There is a link between the three articles in that capacity features, and all three articles contain discussions of the CRPD and one of its central propositions, namely that limitations on capacity as a medical matter should not lead to loss of capacity as a legal matter, namely the right to make decisions about matters that affect the person. Rather, limitations in the former capacity should lead to support to allow the latter capacity to be exercised. See in particular Article 12 of the CRPD; in the context of court processes, Article 13 is also relevant, setting out the need for "procedural and age-appropriate accommodations" to allow participation.

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<sup>2</sup> *Marlon James Noble v Australia* CRPD Committee, Communication No 7/2012, 10 October 2016, [2017] MHLR 215.

<sup>3</sup> *Arturo Medina Vela v Mexico* CRPD Committee, CRPD/C/22/D/32/2015, 15 October 2019, [2024] MHLR 176.



As always, I'd like to express my thanks to authors who submit their articles and those who provide assistance to keep this journal as a wholly open access publication, including peer reviewers and the great supporting team at the University of Northumbria. The commitment of the University to open access journals, importantly produced without article processing charges, is very welcome. One of the great benefits of the digital age should be the ability to access academic work from anywhere: but so many journals are behind expensive paywalls or, if not, have a model of charging authors significant sums in the form of Article Processing Charges to publish work in an open access format. Academic authors, perhaps particularly those working in public institutions or in private institutions which secure subsidies through charitable status, should consider whether direct or indirect public funding for their work should support a preference to publish in a way that allows full public access to their research.

Whatever the motivation of authors, the editorial team welcome contributions from all perspectives, whether in the form of research articles, notes about developments in statutes, policies or jurisprudence, accounts of research in progress, reviews of books, or any other output that might be of interest to readers.

Kris Gledhill

## THE EMOTIONAL LANDSCAPE OF MONEY MANAGEMENT AND COGNITIVE DECLINE: A THERAPEUTIC JURISPRUDENCE PERSPECTIVE

NICOLA GLOVER-THOMAS\*

### ABSTRACT

The ability to manage one's finances is fundamental to independent living, personal autonomy, and overall well-being, particularly for older adults. However, cognitive decline poses a significant threat to this capacity, with profound emotional and psychosocial ramifications for older adults, their families, and the professionals who support them. While legal frameworks like the Mental Capacity Act 2005 (MCA) in England and Wales aim to address these challenges, this article argues that a therapeutic jurisprudence (TJ) perspective offers a crucial lens for understanding and improving outcomes. Drawing upon existing literature in gerontology, neuropsychology, law, and therapeutic jurisprudence, this article considers the complex interplay between cognitive decline, the legal concept of mental capacity in financial decision-making, and emotional well-being. It critiques the potential limitations of purely cognitive or legalistic approaches and advocates for the integration of TJ principles – focusing on psychological well-being, recognising the proactive role of legal actors, and adopting a systemic perspective – to create more humane, effective, and empowering support systems for older adults facing financial vulnerability due to cognitive decline.

**Keywords:** Cognitive Decline, Financial Capacity, Older Adults, Mental Capacity Act 2005, Therapeutic Jurisprudence, Emotions.

### I. INTRODUCTION

For older adults, the autonomous management of financial affairs is crucial for independent living, personal autonomy, and overall well-being. This encompasses a wide array of financial activities, from routine tasks to complex planning, and is deeply entwined with an individual's sense of control, self-worth, and identity.<sup>1</sup> Preserving financial independence empowers older adults to maintain dignity, exercise choices, and actively participate in their communities, fostering social inclusion and upholding personal integrity.<sup>2</sup>

However, ageing often brings a gradual attenuation of cognitive functions, impacting crucial domains for effective financial management, including memory, sustained attention, executive functions (like planning and problem-solving), and information

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<sup>1</sup> Mental Capacity Act 2005; OECD, *Financial Literacy of Older Adults* (OECD 2023). Available at: [https://www.oecd.org/en/publications/oecd-infe-2023-international-survey-of-adult-financial-literacy\\_56003a32-en.html](https://www.oecd.org/en/publications/oecd-infe-2023-international-survey-of-adult-financial-literacy_56003a32-en.html). Accessed 12th May 2025. See also, Lusardi, A. and Mitchell, O.S., 'Financial literacy around the world: an overview' (2011) 10(4) *Journal of Pension Economics & Finance* 497-508; Rowe, J.W. and Kahn, R.L., 'Successful ageing' (1997) 37(4) *The Gerontologist* 433-440; Rowland, D.T., 'Successful Ageing' in *Population Ageing* (Springer 2012).

<sup>2</sup> Dworkin, R., 'Autonomy and the demented self' (1986) *The Milbank Quarterly* 4-16.



processing speed.<sup>3</sup> For a significant proportion of older adults, this decline may develop into mild cognitive impairment or various forms of dementia, progressively eroding their capacity to manage financial affairs effectively and autonomously.<sup>4</sup>

As an individual experiences a decline in their financial mental capacity, they often experience a series of negative consequences that erode both their functional autonomy and their legal agency. Specifically, while the process begins with a diminishing cognitive ability to manage funds, the lived experience quickly translates into a loss of "legal capacity" as defined under Article 12 of the Convention on the Rights of Persons with Disabilities (CRPD).<sup>5</sup> As many jurisdictions still lack the robust supported decision-making regimes that the CRPD arguably mandates, this shift in mental acuity frequently triggers a formal or informal stripping of the individual's right to make legally binding decisions. This intersection of cognitive struggle and legal disenfranchisement increases susceptibility to financial wrongdoing, including fraudulent schemes and scams while gradually hindering the ability to meet basic daily needs. The ultimate result is a substantial loss of control over personal financial resources,<sup>6</sup> a situation that not only harms the individual but also places significant emotional and practical burdens on family caregivers and social service providers who must navigate this increasingly complex landscape.<sup>7</sup>

The escalating prevalence of cognitive decline in ageing societies globally underscores the growing urgency of understanding and effectively addressing the many challenges

<sup>3</sup> Parasuraman, R. (ed.), *The Attentive Brain* (MIT Press 2000); Parasuraman, R. and Haxby, J.V., 'Attention and brain function in Alzheimer's disease: A review' (1993) 7(3) *Neuropsychology* 242; Dempster, F.N., 'The rise and fall of the inhibitory mechanism: Toward a unified theory of cognitive development and ageing' (1992) 12(1) *Developmental Review* 45-75; Squire, L.R., 'Memory and brain systems: 1969-2009' (2009) 29(41) *Journal of Neuroscience* 12711-12716. Salthouse, T.A., 'What and when of cognitive ageing' (2004) 13(4) *Current Directions in Psychological Science* 140-144.

<sup>4</sup> Petersen, R.C., 'Mild cognitive impairment' (2016) 22(2) *CONTINUUM: Lifelong Learning in Neurology* 404-418. Prince, M., Wimo, A., Guerchet, M., Ali, G.C., Wu, Y.T., and Prina, M., *World Alzheimer Report 2015. The Global Impact of Dementia: An analysis of prevalence, incidence, cost and trends* (Alzheimer's Disease International 2015).

<sup>5</sup> Article 12 of the CRPD establishes that individuals with disabilities possess legal capacity on an equal basis with all other citizens across all spheres of life. This principle comprises two fundamental elements: legal standing, which is the recognition of the person as a holder of rights, and legal agency, which is the authority to exercise those rights and enter legally binding transactions.

<sup>6</sup> Fealy, G., Donnelly, N., Bergin, A., Treacy, M.P., and Phelan, A., *Financial Abuse of Older People: A Review* (NCPOP, University College Dublin 2012); Han, S.D., Boyle, P.A., James, B.D., Yu, L., and Bennett, D.A., 'Mild cognitive impairment and susceptibility to scams in old age' (2015) 49(3) *Journal of Alzheimer's Disease* 845-851. See also, Weissberger, G.H., Han, S.D., Yu, L., Barnes, L.L., Bennett, D.A., and Boyle, P.A., 'Financial and health literacy discrepancies with cognition in older adults' (2019) 33(7) *Neuropsychology* 975. See also, Pinsker, D.M., Pachana, N.A., Wilson, J., Tilse, C., and Byrne, G.J., 'Financial capacity in older adults: A review of clinical assessment approaches and considerations' (2010) 33(4) *Clinical Gerontologist* 332-346. Spreng, R.N., Karlawish, J., and Marson, D.C., 'Cognitive, social, and neural determinants of diminished decision-making and financial exploitation risk in ageing and dementia: A review and new model' (2016) 28(4-5) *Journal of Elder Abuse & Neglect* 320-344.

<sup>7</sup> Wittenberg, R., Hu, B., Barraza-Araiza, L., and Rehill, A., *Projections of older people living with dementia and costs of dementia care in the United Kingdom, 2019-2040* (Care Policy and Evaluation Centre, London School of Economics and Political Science 2019); Wittenberg, R., Hu, B., Jagger, C., Kingston, A., Knapp, M., Comas-Herrera, A., et al., 'Projections of care for older people with dementia in England: 2015 to 2040' (2020) 49(2) *Age and Ageing* 264-269.

associated with financial management in this context.<sup>8</sup> The urgency of this challenge is further emphasised by global health statistics: the World Health Organization (WHO) reported that in 2021, an estimated 57 million people were living with dementia worldwide, with nearly 10 million new cases annually. These figures illustrate the profound human cost and growing societal burden, making the effective and humane application of legal principles an increasingly critical imperative.<sup>9</sup> Ensuring the financial security and overall well-being of older adults experiencing cognitive decline necessitates a nuanced and holistic understanding of the intricate interplay between cognitive impairment, financial decision-making, and the significant emotional and psychosocial ramifications for all involved.<sup>10</sup> The already complex area of mental capacity assessment becomes even more challenging due to a lack of shared understanding of what 'emotion' means, how it differs from 'feeling' and 'affect', and consequently, how these emotional aspects should be considered when judging someone's ability to make decisions.<sup>11</sup> This lack of clarity particularly impacts how we apply the legal test for mental capacity to manage finances, as financial decisions are frequently driven by complex emotional motivations, such as the desire to maintain social bonds or a fear of isolation, which may be overlooked by assessments focusing solely on cognitive data.

This article primarily focuses on the legal framework and practical implications within England and Wales, particularly the Mental Capacity Act 2005 (MCA). While rooted in this context, the core challenges highlighted in this article are likely to resonate across other high-income countries facing similar demographic shifts and legal considerations. Legal and policy frameworks need to adapt to protect this vulnerable group, balancing autonomy with safeguarding financial interests. This includes developing clear legal routes for supported decision-making, better use of the MCA and Court of Protection, and implementing stronger legal and practical measures to prevent financial abuse. A deeper, person-centred understanding of the human experience within these frameworks is also crucial, which is where Therapeutic Jurisprudence (TJ) offers a valuable, complementary lens. TJ systematically examines

<sup>8</sup> World Health Organization, *Dementia: a public health priority* (2012); Oeppen, J. and Vaupel, J.W., 'Broken limits to life expectancy' (2002) 296(5570) *Science* 1029-1031; Brookmeyer, R., Johnson, E., Ziegler-Graham, K., and Arrighi, H.M., 'Forecasting the global burden of Alzheimer's disease' (2007) 3(3) *Alzheimer's & Dementia* 186-191; Prince, M., Wimo, A., Guerchet, M., Ali, G.C., Wu, Y.T., and Prina, M., *World Alzheimer Report 2015. The Global Impact of Dementia: An analysis of prevalence, incidence, cost and trends* (Alzheimer's Disease International 2015); Callahan, C., Hendrie, H., and Tierney, W., 'Documentation and evaluation of cognitive impairment in elderly primary care patients' (1995) 122(6) *Ann Intern Med* 422-429.

<sup>9</sup> World Health Organization. 'WHO Fact Sheet on Dementia.' Available at: <https://www.who.int/en/news-room/fact-sheets/detail/dementia>. Accessed 12th May 2025.

<sup>10</sup> Katz, S. and Leibing, A., 'Lost in time like tears in rain': *Critical perspectives on personhood and dementia* in *Critical dementia studies* (Routledge 2023) 57-71; Lichtenberg, P.A., Qualls, S.H., and Smyer, M.A., *Competency and decision-making capacity: Negotiating health and financial decision making* (American Psychological Association 2015).

<sup>11</sup> Stein, N.L., Hernandez, M.W., and Trabasso, T., 'Advances in modeling emotion and thought: The importance of developmental online, and multilevel analyses' in M. Lewis, J.M. Haviland-Jones, and L.F. Barrett (eds), *Handbook of Emotions* (3rd edn, Guilford Press 2008). See also, See Tim Dalgleish and Mick Power (eds), *Handbook of Cognition and Emotion* (John Wiley & Sons 1999); Martha Nussbaum, *Upheavals of Thought: The Intelligence of Emotions* (CUP 2001); Robert Solomon, *Not Passion's Slave: Emotions and Choice* (OUP 2006).

the profound psychological and emotional impacts that legal rules, procedures, and the roles of legal actors have on individuals, positing that the law is not merely a neutral arbiter but an active agent that can produce either therapeutic (positive) or anti-therapeutic (negative) consequences for well-being.<sup>12</sup>

This article seeks to examine how older adults, their families, and social care professionals experience the complex challenges of managing money in the context of cognitive decline, including specific difficulties, emotional responses, and coping mechanisms.<sup>13</sup> Furthermore, it will explore how the MCA effectively addresses these complex challenges, including its strengths, limitations, and areas for improvement in safeguarding the financial well-being of individuals with diminished legal capacity. Therapeutic jurisprudence (TJ) will be explored as a lens to see how psychological harm can be minimised and decision-making empowered, fostering a more supportive legal framework.

## II. TRUST, RELATIONSHIPS, AND FINANCIAL INCAPACITY

The conceptual underpinning of trust and relationships in the context of emotions and financial incapacity reveals a critical interplay between affective bonds, legal frameworks, and the practicalities of managing money. Trust, at its core, represents a reliance on the integrity and goodwill of another, an emotional investment that becomes particularly salient when an individual's cognitive abilities to handle finances diminish. Strong relationships, characterised by shared history, mutual understanding, and emotional closeness, provide a fertile ground for this trust to flourish.

However, the legal framework surrounding capacity seeks to formalise and, in some ways, regulate these trust-based relationships. The MCA, by requiring decision-makers to consider the person's past and present wishes and feelings<sup>14</sup> and to consult with relevant others,<sup>15</sup> implicitly acknowledges how emotional bonds often inform a person's preferences and best interests.

Conversely, the absence of such established trust, as seen in the apprehension towards unknown care professionals, generates emotional friction and highlights the inherent vulnerability felt when financial matters are entrusted to strangers. This is particularly relevant in situations where a person lacks legal capacity, and decisions are made by a court-appointed deputy or an attorney acting under a Lasting Power of Attorney (LPA).<sup>16</sup> The MCA 2005 provides the legal authority for these arrangements, but the emotional reality is that the lack of pre-existing trust can make these legally sanctioned arrangements stressful.

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<sup>12</sup> Wexler, D.B., 'Therapeutic jurisprudence: The law as a therapeutic agent' (1990) 3(2) *New York Law School Journal of Human Rights* 203-217; Winick, B.J., 'The jurisprudence of therapeutic jurisprudence' (1997) 3(1) *Psychology, Public Policy, and Law* 184-219.

<sup>13</sup> Pearlin, L.I., Mullan, J.T., Semple, S.J., and Skaff, M.M., 'Caregiving and the stress process: An overview of concepts and their measures' (1990) 30(5) *The Gerontologist* 583-594.

<sup>14</sup> MCA s 4(6).

<sup>15</sup> MCA s 4(7).

<sup>16</sup> MCA s 9.



Cognitive decline can also change the shape of a relationship over time. For example, a daughter initially appointed as her mother's attorney under an LPA may encounter increasing difficulties as her mother's cognitive impairment progresses, leading to suspicion and resistance. This highlights a potential tension between an LPA's legal validity and the donor's fluctuating emotional state. The MCA 2005 allows for the creation of LPAs, enabling individuals to appoint trusted persons to make financial decisions on their behalf should they lose capacity.<sup>17</sup> However, the burden of responsibility on family members involved in managing the finances of someone who lacks capacity can be significant. This can include the stress of making major decisions, such as selling a house, and the emotional strain of dealing with a person's attachment to their possessions. It can also involve navigating complex interactions with financial organisations or social care providers on behalf of someone who can no longer speak for themselves.<sup>18</sup> While the MCA recognises that capacity can be variable, attorneys must act in the donor's best interests. For some family members, this may cause conflict when the relative with cognitive decline is resistant. Cognitive decline can cause donors to resist prior agreements, creating complex legal and ethical dilemmas. These situations challenge the limits of substituted decision-making, the feasibility of supported decision-making in the face of disagreement, and the crucial balance between individual autonomy and necessary protection.<sup>19</sup>

The management of finances often extends beyond mere practicalities; it is deeply intertwined with an individual's sense of self-worth and identity. The ability to handle one's own money can represent independence and control.<sup>20</sup> Even when an individual cannot demonstrably manage their finances, there often remains a powerful emotional need to maintain a sense of financial agency. This need can significantly influence how capacity is assessed. The inherent dignity associated with financial control may lead professionals to approach assessments of financial capacity with caution; 'taking away' this control can have profound psychological consequences. While the MCA 2005 focuses on a functional test of legal capacity,<sup>21</sup> its emphasis on the person's best interests<sup>22</sup> and considering their wishes and feelings<sup>23</sup> indirectly acknowledges these emotional factors.

A reluctance to discuss finances can also arise from a fear of being accused of wrongdoing or a more general discomfort with financial matters. Some professionals may feel ill-equipped to address financial issues, despite being comfortable discussing other sensitive topics.<sup>24</sup> This highlights the need for training and guidance to equip

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<sup>17</sup> MCA, sch 1.

<sup>18</sup> Bisdee, D., Price, D., and Daly, T., 'Coping with Age-related Threats to Role Identity: Older Couples and the Management of Household Money' (2013) 23(6) *Journal of Community & Applied Social Psychology* 505–518.

<sup>19</sup> Donnelly, M., 'Best Interests in the Mental Capacity Act: Time to Say Goodbye?' (2016) 24(3) *Medical Law Review* 318–332.

<sup>20</sup> Lea, S.E. and Webley, P., 'Money as tool, money as drug: The biological psychology of a strong incentive' (2006) 29(2) *Behavioral and Brain Sciences* 161–176.

<sup>21</sup> MCA ss 2 and 3.

<sup>22</sup> MCA s 4. See also, *A Local Authority v JB* [2021] UKSC 5.

<sup>23</sup> MCA s 4(6).

<sup>24</sup> Hall, A., Straub, C., Price, D., and Glover-Thomas, N., *Managing money in later life: mental capacity assessment and support: Final report* (University of Manchester 2023).

individuals and professionals with the confidence and skills to navigate these conversations. The reluctance to provide practical, hands-on support, such as assisting with banking, often stems from a concern about potential accusations of financial abuse or mismanagement. This is particularly salient when dealing with vulnerable individuals, and professionals rightly emphasise the importance of transparency and accountability.

These emotional and practical challenges underscore the need for a holistic approach to financial incapacity that acknowledges the complex interplay of trust, relationships, emotions, and legal frameworks. Ultimately, the emotional fabric of trust and relationships acts as a crucial mediator in navigating the complexities of financial incapacity. It influences both the willingness to seek and accept help, and the emotional well-being of all parties involved.

### III. THEORETICAL FRAMEWORK: UNPACKING THE INTERPLAY OF COGNITIVE DECLINE, FINANCIAL CAPACITY, AND THERAPEUTIC JURISPRUDENCE

#### *A. Cognitive Decline and Financial Capacity*

As a critical determinant of personal autonomy and overall well-being, financial capacity involves a complex and dynamic interplay of various cognitive abilities that collectively empower individuals to effectively and autonomously manage their financial affairs.<sup>25</sup> Financial capacity requires several intricate cognitive functions.<sup>26</sup> Equally, foundational numeracy skills, encompassing the ability to perform basic calculations, accurately interpret numerical data, and understand fundamental mathematical relationships, are also essential for a wide array of tasks, ranging from basic budgeting and timely bill payment to the comprehension of interest rates, financial statements, and investment returns.<sup>27</sup> Financial capacity relies on the ability to comprehend and reason with often abstract and intricate financial concepts, to accurately discern the potential implications and foreseeable consequences of various financial choices, and to consistently exercise sound judgment in monetary matters, thereby mitigating the risk of adverse financial outcomes.<sup>28</sup> Crucially, however, the threshold for financial capacity is not synonymous with the achievement of an "optimal" or expert-level financial decision. It does not require an individual to possess the technical mastery of a professional, but rather the functional ability to comprehend the fundamental nature, purpose, and core consequences of a specific transaction. Consequently, an individual may retain capacity even when making choices based on factors like brand trust or convenience, provided they grasp the essential weight and

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<sup>25</sup> Townsend, P., *Poverty in the United Kingdom: a survey of household resources and standards of living* (University of California Press 1979).

<sup>26</sup> Squire, L.R., 'Memory and brain systems: 1969–2009' (2009) 29(41) *Journal of Neuroscience* 12711–12716; Parasuraman, R. and Haxby, J.V., 'Attention and brain function in Alzheimer's disease: A review' (1993) 7(3) *Neuropsychology* 242; Dempster, F.N., 'The rise and fall of the inhibitory mechanism: Toward a unified theory of cognitive development and ageing' (1992) 12(1) *Developmental Review* 45–75.

<sup>27</sup> Best, R., Carman, K.G., Parker, A.M., and Peters, E., 'Age declines in numeracy: An analysis of longitudinal data' (2022) 37(3) *Psychology and Ageing* 298.

<sup>28</sup> World Health Organization, *International Statistical Classification of Diseases and Related Health Problems* (11th edn, 2019).

effect of the commitment. These diverse cognitive abilities, operating in a coordinated and integrated manner, collectively empower individuals to undertake essential financial tasks such as managing bank accounts effectively and comprehending diverse financial products (e.g., mortgages, insurance policies, and various investment vehicles), making informed investment decisions that align with their personal financial goals and individual risk tolerance, and, significantly, safeguarding themselves from the ever-present and increasingly sophisticated threat of financial exploitation, a phenomenon of growing legal and societal concern.<sup>29</sup>

The spectrum of cognitive decline, encompassing the normative, age-related changes in cognitive function that occur as part of the natural ageing process, as well as the more pronounced and clinically significant impairments that are characteristic of mild cognitive impairment<sup>30</sup> and various forms of dementia<sup>31</sup> can progressively and insidiously erode these vital cognitive functions, negatively impacting an individual's financial capacity.<sup>32</sup> The ways in which cognitive decline manifests and progresses vary considerably.<sup>33</sup> This variation depends on the underlying neurological disease and the many factors specific to everyone. These differences can have a significant impact on a person's ability to manage their financial affairs effectively<sup>34</sup> and independently.<sup>35</sup>

Individuals experiencing mild cognitive impairment may present with subtle difficulties primarily affecting more complex and novel financial tasks, such as sophisticated investment management or the comprehension of intricate and unfamiliar financial products, while often retaining the capacity to manage more routine and familiar

<sup>29</sup> Jackson, S.L., 'Recognizing the trauma experienced by community-dwelling older victims of financial abuse perpetrated by trusted others' in *Handbook of Interpersonal Violence and Abuse Across the Lifespan: A project of the National Partnership to End Interpersonal Violence Across the Lifespan (NPEIV)* (Springer International Publishing 2021) 4499-4518.

<sup>30</sup> Petersen, R.C., 'Mild cognitive impairment' (2016) 22(2) *CONTINUUM: lifelong Learning in Neurology* 404-418.

<sup>31</sup> Dubois, B., Picard, G., and Sarazin, M., 'Early detection of Alzheimer's disease: new diagnostic criteria' (2009) 11(2) *Dialogues in clinical neuroscience* 135-139; Roman, G.C., 'Defining dementia: clinical criteria for the diagnosis of vascular dementia' (2002) 106 *Acta Neurologica Scandinavica* 6-9; Rascovsky, K., Hodges, J.R., Knopman, D., Mendez, M.F., Kramer, J.H., Neuhaus, J., et al., 'Sensitivity of revised diagnostic criteria for the behavioural variant of frontotemporal dementia' (2011) 134(9) *Brain* 2456-2477.

<sup>32</sup> Marson, D.C., Sawrie, S.M., Snyder, S., McInturff, B., Stalvey, T., Boothe, A., Aldridge, T., Chatterjee, A., and Harrell, L.E., 'Assessing financial capacity in patients with Alzheimer disease: A conceptual model and prototype instrument' (2000) 57(6) *Archives of Neurology* 877-884. Griffith, H.R., Belue, K., Sicola, A., Krzywanski, S., Zamrini, E., Harrell, L., and Marson, D.C., 'Impaired financial abilities in mild cognitive impairment: a direct assessment approach' (2003) 60(3) *Neurology* 449-457; Giannouli, V., 'Neuropsychological Assessment and Financial Capacity in Older Adults: A Review Based on Up-to-Date Knowledge' in L. Ribeiro and A. Ribeiro (eds), *Global Perspectives on Health Assessments for an Ageing Population* (IGI Global 2023) 21-47.

<sup>33</sup> Best, R., Carman, K.G., Parker, A.M., and Peters, E., 'Age declines in numeracy: An analysis of longitudinal data' (2022) 37(3) *Psychology and Ageing* 298.

<sup>34</sup> Allaire, J.C. and Marsiske, M., 'Well-and ill-defined measures of everyday cognition: relationship to older adults' intellectual ability and functional status' (2002) 17(1) *Psychology and Ageing* 101.

<sup>35</sup> Squire, L.R., 'Memory and brain systems: 1969-2009' (2009) 29(41) *Journal of Neuroscience* 12711-12716.

transactions, such as paying regular bills or using cash for everyday purchases.<sup>36</sup> In stark contrast, individuals with more advanced stages of dementia are likely to experience more significant and pervasive impairments across virtually all aspects of financial management, potentially requiring substantial support and assistance even with seemingly simple and routine financial tasks.<sup>37</sup>

Existing models of financial capacity assessment represent a crucial and necessary step in systematically identifying and addressing these complex challenges. These assessments typically employ a comprehensive multi-method approach, obtaining information directly from the individual and, where ethically appropriate, supplementary information from knowledgeable caregivers or close family members.<sup>38</sup> Screening tools are used to provide an objective measure of an individual's cognitive function across various domains that are directly relevant to effective financial decision-making, such as memory, sustained attention, and executive functions.<sup>39</sup> These assessments aim to evaluate an individual's fundamental capacity to understand relevant financial information, to accurately appreciate the potential consequences and broader implications of their financial decisions.

While these models of financial capacity assessment seek to evaluate an individual's cognitive abilities relevant to financial management<sup>40</sup> emphasis remains on identifying cognitive deficits, potentially leading to an incomplete appraisal of the complex interplay of factors that significantly influence an individual's financial decision-making processes.<sup>41</sup> Consequently, these predominantly cognitive models may not adequately capture the significant emotional and psychosocial factors that profoundly shape an individual's subjective experience of decline in mental capacity, their finances and their subsequent interaction with formal and informal support systems.<sup>42</sup> Factors such as heightened anxiety levels, the presence of clinical depression, a diminished sense of self-esteem and personal worth, the pervasive apprehension of becoming an unwanted burden on close family members, and the powerful desire to preserve one's independence can exert a substantial and often underestimated influence on an individual's readiness to openly acknowledge their cognitive limitations, their overall willingness to actively seek or readily accept necessary support, and their overall

<sup>36</sup> Triebel, K.L., Gerstenecker, A., and Marson, D.C., 'Financial and medical decision-making capacity in mild cognitive impairment and dementia' (2018).

<sup>37</sup> Marson, D.C., Sawrie, S.M., Snyder, S., McInturff, B., Stalvey, T., Boothe, A., Aldridge, T., Chatterjee, A., and Harrell, L.E., 'Assessing financial capacity in patients with Alzheimer disease: A conceptual model and prototype instrument' (2000) 57(6) *Archives of Neurology* 877-884.

<sup>38</sup> Kane, R.A., 'The interprofessional team as a small group' (1975) 1(1) *Social Work in Health Care* 19-32.

<sup>39</sup> Lezak, M.D., *Neuropsychological Assessment* (4th edn, Oxford University Press 2004).

<sup>40</sup> Marson, D.C., Sawrie, S.M., Snyder, S., McInturff, B., Stalvey, T., Boothe, A., Aldridge, T., Chatterjee, A., and Harrell, L.E., 'Assessing financial capacity in patients with Alzheimer disease: A conceptual model and prototype instrument' (2000) 57(6) *Archives of Neurology* 877-884.

<sup>41</sup> Xiao, J.J. and O'Neill, B., 'Disability type, financial capability, and risky asset holding' (2022) 32(4) *Journal of Disability Policy Studies* 269-279.

<sup>42</sup> Pinsker, D.M., Pachana, N.A., Wilson, J., Tilse, C., and Byrne, G.J., 'Financial capacity in older adults: A review of clinical assessment approaches and considerations' (2010) 33(4) *Clinical Gerontologist* 332-346.

engagement with financial matters.<sup>43</sup> Therefore, a more holistic and comprehensive understanding of financial capacity in the complex context of cognitive decline necessitates the adoption of a broader and more integrated perspective that thoughtfully incorporates these crucial emotional and psychosocial dimensions alongside the traditional, and often narrowly defined, legal and cognitive evaluation of capacity.<sup>44</sup>

### *B. The Mental Capacity Act 2005: Principles and Practice*

The MCA constitutes a pivotal legislative framework in England and Wales, establishing a statutory basis for decision-making on behalf of adult individuals who lack the requisite legal capacity to make specific decisions for themselves.<sup>45</sup> Central to the MCA are five fundamental principles that underpin its application, aiming to both safeguard the rights and promote the well-being of vulnerable individuals, while concurrently striving to uphold their autonomy.<sup>46</sup>

The presumption of capacity forms the bedrock of the Act, establishing a robust legal starting point wherein every adult is presumed to possess the capacity to make their own decisions unless and until it is demonstrated, on the balance of probabilities, that they lack such legal capacity in relation to a specific decision at a specific time.<sup>47</sup> This presumption places the legal burden of proof on those asserting a lack of capacity<sup>48</sup> and underscores the paramount importance of respecting individual autonomy.<sup>49</sup>

Recognising the dynamic nature of capacity, which can fluctuate and be influenced by factors such as temporary impairments or the environmental context, the principle of supporting decision-making mandates that all practicable steps must be taken to assist an individual in making a decision before a conclusion of incapacity is reached.<sup>50</sup> This proactive legal obligation necessitates the exploration of diverse communication methods, the provision of accessible and comprehensible information tailored to the individual's needs,<sup>51</sup> and the consideration of alternative ways of presenting choices to enable the individual's greatest participation in the decision-making process, aligning with the concept of supported decision-making.<sup>52</sup>

The principle concerning unwise decisions draws a critical distinction between a lack of legal capacity, a legal determination of decision-making inability, and the making of a decision deemed unwise, imprudent, or not in the individual's perceived best

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<sup>43</sup> World Health Organization, *International Statistical Classification of Diseases and Related Health Problems* (11th edn, 2019).

<sup>44</sup> Higgs, P. and Gilleard, C., 'Interrogating personhood and dementia' (2016) 20(8) *Ageing & Mental Health* 773-780.

<sup>45</sup> Braye, S. and Preston-Shoot, M., *Practising Social Work Law* (4th edn, Bloomsbury Publishing 2017).

<sup>46</sup> Herring, J., *Medical Law and Ethics* (7th edn, Oxford University Press 2022).

<sup>47</sup> MCA s 1(2).

<sup>48</sup> Brazier, M. and Miola, J., 'Releasing the kracken: The Mental Capacity Act 2005' (2004) 12(2) *Medical Law Review* 268-293.

<sup>49</sup> Dworkin, R., 'Autonomy and the demented self' (1986) 64(Supp 2) *The Milbank Quarterly* 4-16.

<sup>50</sup> MCA s 1(3).

<sup>51</sup> Jackson, E., *Medical Law: Text, Cases, and Materials* (6th edn, Oxford University Press 2019).

<sup>52</sup> Kohn, N.A., 'Legislating supported decision-making' (2021) 58 *Harv. J. on Legis.* 31.

interests.<sup>53</sup> An individual's right to make choices with which others may disagree is upheld and protected, provided they possess the legal capacity to understand the relevant information, appreciate the reasonably foreseeable consequences of their choice, and make that choice freely and without undue influence. This principle serves as a safeguard against paternalistic interventions predicated solely on a subjective evaluation of a decision's perceived wisdom.<sup>54</sup>

Where an individual is legally determined to lack the legal capacity to make a specific decision at a specific time, the principle of best interests dictates that any act done, or decision made on their behalf must be in their best interests.<sup>55</sup> This principle necessitates a careful, holistic, and individualised assessment, considering a range of factors relevant to the specific decision, including the individual's past and present wishes and feelings, their beliefs and values, the views of relevant others (such as family, carers, and appointed representatives), and the potential consequences of the decision.<sup>56</sup> The Act provides a non-exhaustive checklist of factors to be considered in determining best interests, emphasising a person-centred approach<sup>57</sup> that prioritises the individual's unique needs, preferences, and perspectives.

Finally, the principle of the less restrictive option underscores the importance of proportionality and necessity in interventions, reflecting the broader legal principle of respect for individual liberty. Prior to any action or decision on behalf of someone lacking capacity, consideration must be given to whether the desired outcome can be as effectively achieved in a manner that is less restrictive of the individual's rights and freedom of action.<sup>58</sup> This principle promotes the adoption of the least intrusive options that are still effective in meeting the individual's needs and safeguarding their well-being, while minimising any unnecessary curtailment of their autonomy.<sup>59</sup>

Beyond these core principles, the MCA establishes crucial legal mechanisms for supporting financial decision-making and facilitating planning for potential future incapacity. Lasting Powers of Attorney (LPAs), a key instrument under the Act, empower individuals with capacity to appoint trusted individuals (attorneys) to make financial decisions on their behalf should they subsequently lose capacity.<sup>60</sup> This mechanism promotes individual autonomy and self-determination by allowing individuals to choose who will manage their financial affairs if they become unable to do so themselves. In situations where individuals lack capacity and have not previously sought an LPA, the Court of Protection, holds the statutory authority to make decisions on their behalf and to appoint deputies to manage their property and affairs.<sup>61</sup> These

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<sup>53</sup> MCA s 1(4).

<sup>54</sup> Beauchamp, T.L. and Childress, J.F., *Principles of Biomedical Ethics* (8th edn, Oxford University Press 2019).

<sup>55</sup> MCA s 1(5).

<sup>56</sup> MCA s 4.

<sup>57</sup> Kitwood, T.M., *Dementia Reconsidered: The Person Comes First* (Open University Press 1997).

<sup>58</sup> MCA s 1(6).

<sup>59</sup> Szmukler, G. and Dawson, J., 'Reducing discrimination' in *Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects* (Cambridge University Press 2011) 97.

<sup>60</sup> MCA s 9; MCA, sch 1.

<sup>61</sup> MCA s 16.

deputies are subject to the Court's ongoing oversight and are legally obligated to always act in the individual's best interests.<sup>62</sup>

While the MCA represents a significant and progressive legal framework designed to protect vulnerable individuals and facilitate necessary financial management when legal capacity is lacking, its practical application, particularly in the complex and nuanced context of cognitive decline, is not without limitations and has been subject to critical analysis.<sup>63</sup> A primary concern raised by commentators centres on the potential for the capacity assessment process, as implemented in practice, to overemphasise cognitive deficits, sometimes at the expense of a more holistic and person-centred understanding of the individual's retained functional abilities and their broader preferences.<sup>64</sup> The standardised cognitive assessments frequently employed may not always fully capture the subtle nuances of an individual's preserved functional abilities or adequately account for the potentially significant impact of emotional and psychosocial factors on their engagement with financial matters.<sup>65</sup> For example, an individual experiencing acute anxiety or feeling overwhelmed by the assessment environment might perform sub-optimally on a cognitive test, potentially leading to an underestimation of their actual decision-making capacity in a more supportive and familiar setting.<sup>66</sup>

Furthermore, the practical application of the best interests principle in financial contexts can be particularly challenging and ethically complex.<sup>67</sup> Balancing an individual's deeply ingrained wishes, values, and beliefs with their current and potentially conflicting needs and circumstances, which may be altered by cognitive decline, necessitates careful deliberation and often involves navigating sensitive dilemmas. Determining what truly aligns with an individual's best interests in such circumstances can be inherently subjective and may inevitably involve difficult value-based trade-offs, particularly when there is significant disagreement among relevant parties.

Moreover, the Act's provisions arguably do not allow space for the emotional and psychosocial impact on family members who often bear substantial responsibility for recognising declining financial capacity in a loved one, initiating difficult and emotionally charged conversations about financial management, and potentially

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<sup>62</sup> MCA s 4.

<sup>63</sup> Series, L., 'Relationships, autonomy and legal capacity: Mental capacity and support paradigms' (2015) 40 *International Journal of Law and Psychiatry* 80-91.

<sup>64</sup> Lichtenberg, P.A., Rorai, V., and Flores, E.V., 'A person-centered approach to financial capacity: early memory loss, financial management and decision-making' (2024) 28(10) *Ageing & Mental Health* 1383-1389.

<sup>65</sup> Pinsker, D.M., Pachana, N.A., Wilson, J., Tilse, C., and Byrne, G.J., 'Financial capacity in older adults: A review of clinical assessment approaches and considerations' (2010) 33(4) *Clinical Gerontologist* 332-346.

<sup>66</sup> Kahneman, D. and Tversky, A., 'Prospect theory: An analysis of decision under risk' in G.M. <sup>1</sup> Constantinides, M. Harris, and R.M. Stulz (eds), *Handbook of the fundamentals of financial decision making: Part I* (Elsevier 2013) 99-127.

<sup>67</sup> Dresser, R., 'On legalizing physician-assisted death for dementia' (2017) 47(4) *Hastings Center Report* 5-6.

assuming formal or informal decision-making roles.<sup>68</sup> The emotional burden experienced by these caregivers, the potential for intrafamilial conflict arising from differing perspectives on financial management, and the complexities of navigating the often intricate legal processes under the MCA can be considerable and warrant greater attention. Similarly, professionals involved in assessing capacity and implementing support, such as social care workers, healthcare providers, and legal practitioners, may face ethical and practical challenges in effectively balancing the imperative to protect vulnerable individuals from financial harm with the equally important imperative to respect their autonomy and dignity, particularly when individuals express resistance or dissent to proposed interventions.

### *C. Therapeutic Jurisprudence: A Framework for Understanding and Enhancing Legal Interactions*

Therapeutic Jurisprudence (TJ) has emerged as an established school of legal thought<sup>69</sup> that examines the impact of legal rules and procedures on the emotional and psychological well-being of individuals.<sup>70</sup> Since its inception, TJ has encouraged a shift in legal analysis beyond traditional lenses of rights and duties, suggesting that legal processes are not neutral;<sup>71</sup> they inevitably produce consequences that can be characterised as either therapeutic or anti-therapeutic for those interacting with the legal system.

Consequently, TJ advocates for an evaluation of legal procedures and the roles of legal actors based on these human consequences. This approach urges a move towards practices and policies that are more consciously attuned to promoting well-being and minimising psychological harm.<sup>72</sup> This necessitates moving beyond a purely legalistic or doctrinal approach, which often overlooks the lived experiences of those subject to the law.<sup>73</sup> In the context of financial capacity and the Mental Capacity Act, TJ provides a valuable framework for assessing how legal interventions might better support the dignity and autonomy of vulnerable individuals while navigating the complex interpersonal dynamics involved in caregiving and legal oversight.<sup>74</sup> The foundational principle of TJ explicitly places the emotional and psychological impact of legal

<sup>68</sup> Schulz, R. and Martire, L.M., 'Family caregiving of persons with dementia: prevalence, health effects, and support strategies' (2004) 12(3) *The American Journal of Geriatric Psychiatry* 240-249.

<sup>69</sup> Stobbs N, Bartels L and Vols M (eds), *The Methodology and Practice of Therapeutic Jurisprudence* (Carolina Academic Press 2019). See also, Wexler, D.B. and Winick, B.J. (eds), *Essays in Therapeutic Jurisprudence* (Carolina Academic Press 1991).

<sup>70</sup> Wexler DB, 'Moving Forward on Mainstreaming Therapeutic Jurisprudence: An International Perspective' (2014) 37(1) *International Journal of Law and Psychiatry* 5.

<sup>71</sup> Brookbanks, W. (Ed.). *Therapeutic Jurisprudence: New Zealand Perspectives* (Thomson Reuters 2015).

<sup>72</sup> Perlin, M., Ellis Cucolo, H., and Lynch, A., *Mental Disability Law: Cases and Materials* (3rd edn, Carolina Academic Press 2017). See also, Perlin, M.L. and Lynch, A.J., 'Therapeutic Jurisprudence' in *Sexuality, Disability, and the Law: Beyond the Last Frontier?* (Palgrave Macmillan US 2016) 145-157; David B Wexler, *Therapeutic Jurisprudence: The Law as a Therapeutic Agent* (Carolina Academic Press 1990).

<sup>73</sup> Winick, B.J., 'The jurisprudence of therapeutic jurisprudence' (1997) 3(1) *Psychology, Public Policy, and Law* 184.

<sup>74</sup> Stolle, D.P., Wexler, D.B., Winick, B.J., and Dauer, E.A., 'Integrating preventive law and therapeutic jurisprudence: A law and psychology-based approach to lawyering' (1997) 34 *Cal. WL Rev.* 15.

interventions at the forefront of legal inquiry and legal reform.<sup>75</sup> It challenges the traditional, and often idealised, view of judges, lawyers, and other legal professionals as detached arbiters or mere interpreters and appliers of abstract legal rules. Instead, it suggests that these legal actors have a proactive and ethical responsibility to be consciously mindful of the therapeutic implications of their actions, decisions, and communication styles.<sup>76</sup> This involves actively striving to minimise potential psychological harm to individuals involved in the legal system and, where ethically and legally permissible, to promote their psychological well-being.<sup>77</sup> This proactive stance requires the development of skills in empathetic communication, a nuanced understanding of the psychological vulnerabilities of individuals facing legal issues, and the adoption of problem-solving approaches that prioritise therapeutic outcomes alongside traditional legal objectives.

TJ acknowledges that the law operates within a complex and interconnected web of social, cultural, and economic factors that can significantly influence its therapeutic effects and overall impact on well-being.<sup>78</sup> It therefore encourages a systemic and contextualised analysis that considers how legal rules, procedures, and practices interact with these broader contextual elements to produce their ultimate impact on individual and community well-being. This systemic perspective highlights the critical importance of addressing systemic barriers, power imbalances, and social inequalities that may contribute to anti-therapeutic outcomes and of fostering a more supportive and therapeutic legal culture within the legal system and society.

This TJ perspective proves particularly valuable for analysing the challenges of assessing and supporting financial capacity in cognitive decline.<sup>79</sup> TJ compels a shift beyond purely cognitive or legalistic understandings, urging consideration of the multilayered emotional and psychological ramifications for older adults with cognitive decline, their families, and their support professionals. TJ encourages us to expand the scope of our inquiry beyond narrow legal questions, such as 'can this person legally make a financial decision?' or 'what does the law explicitly allow us to do in this specific situation?', and to incorporate more person-centred and ethically informed questions, such as 'how will this particular assessment process or support intervention impact this person's fundamental sense of dignity, self-worth, and overall psychological well-being?' and 'how can we proactively design legal and support systems that are more therapeutic in their effects, promoting positive outcomes and minimising potential harms?'

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<sup>75</sup> Wexler, D.B., 'Therapeutic jurisprudence: The law as a therapeutic agent' (1990) 3(2) *New York Law School Journal of Human Rights* 203-217; Winick, B.J., 'The jurisprudence of therapeutic jurisprudence' (1997) 3(1) *Psychology, Public Policy, and Law* 184-219.

<sup>76</sup> Stolle, D.P., Wexler, D.B., Winick, B.J., and Dauer, E.A., 'Integrating preventive law and therapeutic jurisprudence: A law and psychology-based approach to lawyering' (1997) 34 *Cal. WL Rev.* 15.

<sup>77</sup> Perlin, M.L., 'Have You Seen Dignity?': The Story of the Development of Therapeutic Jurisprudence' (2017) *The Story of the Development of Therapeutic Jurisprudence* (March 13, 2017).

<sup>78</sup> Wexler, D.B. and Winick, B.J. (eds), *Essays in Therapeutic Jurisprudence* (Carolina Academic Press 1991).

<sup>79</sup> Stolle, D.P., 'Professional Responsibility in Elder Law: A Synthesis of Preventive Law and Therapeutic Jurisprudence' (1996) 14(4) *Behavioral Sciences & the Law* 459-478.

TJ stresses that any help provided – from assessing someone's decision-making ability to offering support or imposing deputyship – should limit their freedom as little as possible. It means actively seeking and carefully considering what the individual wants, prefers, and *can still do*, as much as is ethically and legally allowed.<sup>80</sup> This involves enabling people to genuinely participate in decisions about their lives and consciously avoiding actions or words that might make them feel like children, powerless, or like they no longer have control.<sup>81</sup>

Fostering open, empathetic, respectful, and collaborative communication between older adults, their family members, and all involved professionals is essential.<sup>82</sup> It is important to recognise, acknowledge, and proactively respond to the complex and often profound emotional challenges faced by individuals as they experience a decline in their financial capacity and the associated loss of independence and control.<sup>83</sup> This approach moves beyond a purely protective or regulatory stance, which may inadvertently prioritise legal compliance over individual well-being, to actively promote emotional and psychological well-being, preserve dignity, and strengthen the vital social connections that are essential for the overall quality of life of individuals and their families navigating these difficult and often life-altering circumstances.<sup>84</sup>

While TJ offers a valuable framework for analysing the law's impact on psychological well-being, it is important to acknowledge areas of challenge. One key concern revolves around the potential for TJ to prioritise therapeutic goals at the expense of other fundamental legal values, such as justice, fairness, and individual rights. As Fox notes, there is a risk that the pursuit of therapeutic outcomes could lead to coercive or paternalistic interventions that undermine individual autonomy and procedural justice.<sup>85</sup> Concerns have also been raised from the perspective of human rights, particularly disability rights, suggesting that TJ's focus, if not carefully balanced, could inadvertently lead to interventions that limit rather than enhance autonomy.<sup>86</sup> With TJ focusing on the psychological well-being of the legal actors, other important dimensions of human experience may be neglected, such as social, economic, and

<sup>80</sup> Herring, J., *Medical Law and Ethics* (7th edn, Oxford University Press 2022).

<sup>81</sup> Weierich, M.R., Kensinger, E.A., Munnell, A.H., Sass, S.A., Dickerson, B.C., Wright, C.I., and Barrett, L.F., 'Older and wiser? An affective science perspective on age-related challenges in financial decision making' (2011) 6(2) *Social Cognitive and Affective Neuroscience* 195-206.

<sup>82</sup> Petrucci, C.J., Winick, B.J., and Wexler, D.B., 'Therapeutic jurisprudence: An invitation to social scientists' in *Handbook of Psychology in Legal Contexts* (2nd edn, John Wiley & Sons 2003) 579-601.

<sup>83</sup> Hennelly, N., Cooney, A., Houghton, C., and O'Shea, E., 'Personhood and dementia care: A qualitative evidence synthesis of the perspectives of people with dementia' (2021) 61(3) *The Gerontologist* e85-e100.

<sup>84</sup> Winick, B.J., 'The jurisprudence of therapeutic jurisprudence' (1997) 3(1) *Psychology, Public Policy, and Law* 184.

<sup>85</sup> Fox, D.R., 'Psychological jurisprudence and radical social change' (1993) 48(3) *American Psychologist* 234. See also, Petrucci, C.J., Winick, B.J., and Wexler, D.B., 'Therapeutic jurisprudence: An invitation to social scientists' in N.K. Rattan and R.J.R. MacKay (eds), *Handbook of Psychology in Legal Contexts* (John Wiley & Sons 2003) 579-601.

<sup>86</sup> Arstein-Kerslake, A., and Black, J. 'Right to legal capacity in therapeutic jurisprudence: Insights from critical disability theory and the Convention on the Rights of Persons with Disabilities.' (2020) 68 *International Journal of Law and Psychiatry* 101538.

cultural factors.<sup>87</sup> Yet despite these criticisms, TJ remains a valuable and evolving framework for legal analysis and reform.

#### *D. Critical Discussion of the Legal Framework through a Therapeutic Jurisprudence Lens*

While the MCA provides a robust legal foundation, a critical examination through the lens of TJ reveals areas where its practical application can be enhanced to better serve the psychological well-being of individuals with cognitive decline and their families. TJ encourages a shift from a purely procedural adherence to the Act's principles to a more nuanced consideration of their therapeutic impact.

First, while the MCA mandates the presumption of capacity and the duty to support decision-making, TJ highlights the crucial importance of how these principles are implemented. A TJ-informed approach would push for a deeper inquiry into the psychological environment of assessment and support. For instance, an assessment conducted in an unfamiliar, clinical setting by a detached professional might inadvertently create anxiety or distress, hindering an individual's ability to demonstrate their true capacity. A TJ-informed approach would advocate for assessments to be conducted in a person-centred manner, in familiar surroundings, and by professionals trained in empathetic communication, thereby fostering a more therapeutic atmosphere that maximises the individual's ability to participate and retain a sense of agency. This perspective strongly aligns with and enhances the concept of supported decision-making, moving beyond mere provision of information to actively co-creating an environment where the individual feels empowered and understood, thus promoting their self-determination as much as possible. This aligns with the TJ principle of minimising anti-therapeutic outcomes.

Secondly, the MCA's central best interests principle, while crucial, often causes significant emotional distress and conflict in financial contexts. TJ would critically examine its application, ensuring active incorporation of the individual's subjective experiences, values, and wishes—even when imperfectly expressed due to cognitive decline. This extends beyond merely consulting family members (as per MCA s 4(7)) to genuinely seeking to understand the person's lifelong narrative and preferences, fostering continuity and identity respect. Where there are disagreements, a TJ approach would promote mediation and collaborative problem-solving, aiming to reduce the adversarial nature of disputes and mitigate psychological harm to all parties. This resonates with TJ's focus on promoting well-being and strengthening relationships within the legal process.

Thirdly, TJ illuminates the potential for the MCA's focus on functional capacity to inadvertently dehumanise or disempower individuals. By primarily identifying deficits, the legal framework, if applied too narrowly, risks overlooking an individual's retained strengths, emotional needs, and desire for continued financial agency. A TJ

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<sup>87</sup> Perlin, M.L., 'A law of healing' (1999) 68 *University of Cincinnati Law Review* 407; Wexler, D.B., 'Therapeutic jurisprudence and the culture of critique' (2000) 23(5-6) *International Journal of Law and Psychiatry* 513-525.

perspective would advocate for a strengths-based approach, even within the legal assessment, seeking to identify and leverage remaining abilities and preferences to maximise autonomy. This could involve exploring creative supported decision-making arrangements that are not explicitly detailed but are permissible under the MCA's broad principles, rather than defaulting to more restrictive options like deputyship. This proactive stance aligns with TJ's emphasis on legal actors having a therapeutic responsibility.

Finally, TJ critiques the lack of explicit consideration for the emotional and psychosocial impact on family caregivers and professionals within the MCA. While the Act provides legal mechanisms, it does not directly address the emotional burden, moral distress, or potential for conflict that can arise. A TJ-informed legal system would acknowledge these human dimensions, advocating for support services, training, and processes that mitigate these negative impacts. This could include mandatory training on communication strategies for professionals dealing with families, or the provision of accessible legal and emotional support for family members navigating complex financial decisions on behalf of a loved one. Such an approach would embody TJ's systemic perspective, recognising that the well-being of all involved parties contributes to a more just and therapeutic outcome.

#### IV. THE EMOTIONAL AND PSYCHOSOCIAL DIMENSIONS OF DECLINING FINANCIAL CAPACITY

Beyond its cognitive aspects, the decline in financial capacity manifests as a profoundly emotional and psychosocial experience, deeply impacting older adults, their families, and care professionals.<sup>88</sup> The reduction of financial independence can precipitate a cascade of negative emotions, such as shame, anger, and grief, often accompanied by a loss of self-worth and a fundamental challenge to an individual's established identity.<sup>89</sup> Family members, in turn, often confront substantial emotional burdens, including anxiety, frustration, and moral distress, as well as complex ethical dilemmas in navigating the complexities of supporting their loved ones. Professionals, caught between the imperatives of protection and the preservation of autonomy, grapple with equally challenging issues, often experiencing role strain and moral injury.<sup>90</sup>

The MCA, while undoubtedly a crucial legislative instrument, may not, in its current form, be able to address these emotional and psychosocial dimensions. Its primary focus on cognitive capacity, while essential, can sometimes overshadow the affective and social aspects of decision-making, potentially leading to interventions that, while legally sound, are experienced as disempowering and dehumanising.

<sup>88</sup> Pinsker, D.M., Pachana, N.A., Wilson, J., Tilse, C., and Byrne, G.J., 'Financial capacity in older adults: A review of clinical assessment approaches and considerations' (2010) 33(4) *Clinical Gerontologist* 332-346; Widera, E., Steenpass, V., Marson, D., and Sudore, R., 'Finances in the older patient with cognitive impairment: 'He didn't want me to take over'' (2011) 305(7) *JAMA* 698-706.

<sup>89</sup> Guberman, N., Gagnon, É., Lavoie, J.P., Belleau, H., Fournier, M., Grenier, L., and Vézina, A., 'Families' values and attitudes regarding responsibility for the frail elderly: Implications for ageing policy' (2006) 18(3-4) *Journal of Ageing & Social Policy* 59-78.

<sup>90</sup> Chan, A.C. and Stum, M.S., 'The state of theory in elder family financial exploitation: A systematic review' (2020) 12(4) *Journal of Family Theory & Review* 492-509.

### *A. Therapeutic Jurisprudential Framework: Core Implications*

The application of a TJ lens to the assessment of financial capacity and the provision of support entails several key shifts in perspective and practice. A fundamental reorientation is required, one that centres on communication and empathy. The language employed must be person-centred, and the environment one that fosters a safe and supportive dialogue. A failure to acknowledge the emotional context of financial incapacity can lead to resistance, non-compliance, and a breakdown of trust,<sup>91</sup> ultimately undermining the goals of the intervention.

Furthermore, a TJ approach mandates a focus on functional abilities and support. Traditional assessments, as operationalised under the MCA, often prioritise a cataloguing of deficits, thereby potentially overlooking an individual's residual strengths and capabilities. A more nuanced approach would entail a thorough evaluation of these remaining strengths, coupled with the exploration and implementation of strategies to support decision-making. This ensures that an individual's autonomy is maximised to the greatest extent possible, recognising that even with cognitive decline, individuals retain agency and the right to self-determination.

The legal and procedural framework itself, as shaped by the MCA, must be re-envisioned to create a less adversarial process. All too often, assessment processes are perceived as threatening and disempowering exacerbating anxiety. A TJ framework calls for a restructuring of these processes, emphasising collaboration and empowerment. This involves actively involving the individual in the decision-making process, respecting their perspective, and fostering a sense of partnership rather than paternalism, aligning with the MCA's emphasis on participation. This shift necessitates a move away from a purely legalistic and adversarial approach towards a more collaborative and therapeutic one, where the individual's voice is heard and their preferences are considered.

The overarching goal should be the promotion of autonomy and choice. Even in the context of cognitive decline, individuals retain a fundamental right to self-determination. Support systems should be designed to empower individuals to maintain control over their financial affairs for as long as possible. This may involve the utilisation of supported decision-making frameworks, which provide individuals with the assistance they need to make their own choices, rather than substituting the judgment of others, a concept that while present in the MCA, could be more robustly implemented. This approach recognises that autonomy is not an all-or-nothing concept, but rather a spectrum,<sup>92</sup> and that even individuals with significant cognitive impairment can make meaningful choices with appropriate support. It also necessitates the development of tailored interventions that are responsive to the

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<sup>91</sup> Wexler, D.B., 'Therapeutic jurisprudence: The law as a therapeutic agent' (1989) 68 *Nebraska Law Review* 1.

<sup>92</sup> Devi, N., 'Supported decision-making and personal autonomy for persons with intellectual disabilities: Article 12 of the UN Convention on the Rights of Persons with Disabilities' (2013) 41(4) *The Journal of Law, Medicine & Ethics* 792-806.

unique needs and circumstances of everyone, recognising that there is 'no one-size-fits-all' solution. Peer support programmes, for instance, could be a powerful tool for reducing isolation and promoting resilience among older adults. These programmes work by connecting individuals who share similar experiences of financial incapacity, whether they are directly affected or are supporting a relative.<sup>93</sup>

### *B. Critical Considerations for Implementing a Therapeutic Jurisprudential Approach*

The successful implementation of a TJ approach necessitates a fundamental shift in the way professionals and legal systems interact with individuals experiencing cognitive decline.<sup>94</sup> A cornerstone of this effort must be the development of better training for professionals.<sup>95</sup> These should go beyond knowledge sharing and should place a strong emphasis on the emotional and psychosocial aspects of financial capacity decline, equipping professionals with the essential skills in empathetic communication, supported decision-making, and conflict resolution. This training should also foster attitudinal changes, encouraging professionals to adopt a more person-centred and less paternalistic approach, aligning with the spirit, if not always the practice, of the MCA. A critical element of this training should involve experiential learning, allowing professionals to develop a deeper understanding of the lived experiences of individuals with cognitive decline and their families.<sup>96</sup>

There is also a need for the development of new and specialised support services. Existing services are often fragmented and poorly integrated, making it difficult for individuals and families to access the help they need.<sup>97</sup> This fragmentation can lead to confusion, duplication of effort, and gaps in service provision.<sup>98</sup> New services should be designed to be integrated and holistic, offering a range of assistance, including emotional support, tailored financial education, and practical assistance. A key principle guiding the development of these services should be the maximisation of autonomy and the preservation of dignity, within the boundaries of legal frameworks such as the MCA. This should be reflected in the design and delivery of services, ensuring that individuals are at the centre of the decision-making process and that their preferences and values are given due weight.<sup>99</sup>

<sup>93</sup> Hall, A., Straub, C., Price, D., and Glover-Thomas, N., *Managing money in later life: mental capacity assessment and support: Final report* (University of Manchester 2023).

<sup>94</sup> Winick, B.J., 'The Jurisprudence of Therapeutic Jurisprudence' (1997) 3 *Psychology, Public Policy and Law* 184.

<sup>95</sup> Yamada, D.C., 'Teaching therapeutic jurisprudence' (2020) 50 *U. Balt. L. Rev.* 425.

<sup>96</sup> Breakey, H., 'Building ethics regimes: Capabilities, obstacles and supports for professional ethical decision-making' (2017) 40(1) *University of New South Wales Law Journal* 322-352; Hall, A., Straub, C., Price, D., and Glover-Thomas, N., *Managing money in later life: mental capacity assessment and support: Final report* (University of Manchester 2023).

<sup>97</sup> Sabatino, C.P., 'The legal and functional status of the medical proxy: suggestions for statutory reform' (1999) 27(1) *Journal of Law, Medicine & Ethics* 52-68.

<sup>98</sup> Glover-Thomas, N. (2008). Joint working: Reality or rhetoric in housing the mentally vulnerable? *Journal of social welfare & family law*, 29(3-4), 217-231.

<sup>99</sup> Kohn, N.A., 'Legislating supported decision-making' (2021) 58 *Harv. J. on Legis.* 313.

## V. CONCLUSION

Examining how emotions effect managing money when cognitive skills decline, especially through the perspective of TJ, highlights a crucial but often ignored aspect of ageing. The erosion of financial autonomy transcends mere functional impairment; it strikes at the heart of an individual's sense of self, dignity, and independence, often triggering a cascade of negative emotions, including anxiety, frustration, shame, and a palpable loss of control. For family caregivers, navigating the complexities of supporting a loved one's financial affairs while witnessing their cognitive decline engenders emotional burdens, ethical dilemmas, and the potential for interpersonal strain. Similarly, professionals operating within existing legal frameworks, face the delicate and ethically charged task of balancing the imperative to safeguard vulnerable individuals with the fundamental need to respect their autonomy and inherent dignity, a balance that purely legalistic approaches may struggle to fully achieve.

TJ offers a transformative perspective, advocating for a paradigm shift that prioritises the psychological well-being of all stakeholders involved. By explicitly acknowledging the law's inherent therapeutic or anti-therapeutic effects, TJ compels a critical re-evaluation of current legal frameworks, professional practices, and support systems. Building on the critique of purely cognitive assessments, TJ champions a holistic, person-centred approach that actively considers the individual's retained abilities, emotional experiences, and the broader psychosocial context. A TJ-informed approach necessitates a fundamental reorientation towards empathetic communication, the creation of less adversarial assessment processes, and the proactive integration of emotional support services. It champions the implementation of supported decision-making models that empower individuals to maintain maximum control over their financial lives, even in the face of cognitive impairment, thereby preserving their sense of agency and self-worth.

Ultimately, the integration of TJ principles into the fabric of legal frameworks, professional training, and the design of social support systems represents a crucial step towards cultivating a more humane, ethically sound, and demonstrably effective ecosystem for supporting older adults navigating the intricate challenges of financial management in the context of cognitive decline. This holistic perspective moves beyond a purely protective or regulatory stance, which risks inadvertently prioritising legal compliance over individual well-being, towards a more compassionate and empowering model that actively promotes emotional and psychological resilience, safeguards dignity, and strengthens the vital social connections that are indispensable for the overall quality of life of individuals and their families confronting these often-profound life transitions. Policy development should shift towards a more person-centred ethos, crafting legal and social care frameworks that are not only legally sound but also psychologically sensitive and genuinely supportive. By embracing TJ, society can move towards creating a more just, compassionate, and empowering environment for older adults facing the complexities of managing their financial lives in the face of cognitive change.

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## **“IT’S A VERY COMPLEX THING”: DISCOURSE ABOUT CAPACITY IN AUSTRALIA’S NORTHERN TERRITORY**

HANNAH QUADRIO\*

### **ABSTRACT**

In the years following the introduction of the Convention on the Rights of Persons with Disabilities (CRPD), there has been considerable debate about the validity of ‘lack of capacity’ as a legal justification for involuntary (unconsented) psychiatric treatment. In Australia however, mental health legislation reforms completed following the CRPD have not resulted in the abandonment of substituted decision-making based on lack of capacity. Capacity considerations remain relevant.

The Northern Territory (NT) of Australia has been undertaking a prolonged review of its current mental health legislation. It is expected to soon become the last Australian jurisdiction to introduce new mental health legislation following the CRPD. This paper presents the findings of a recent study of capacity discourse, involving a review of NT caselaw and an interview with a medical practitioner. The data collected provides support for defining the concept of capacity when it is used in legislation; it suggests that when ‘capacity’ is left *undefined* in legislation, the test for capacity can become vague, amorphous, subjective, and focused on compliance.

The study of capacity discourse enhances the visibility of decision-making about capacity under current NT mental health law. From a methodology perspective, the study highlights how interviews with clinicians can provide rich data about how mental health law is understood and operationalised in practice.

**Keywords:** mental health, capacity, consent, insight, legislation, definition, assessment, reform, Australia, Northern Territory

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## INTRODUCTION

Australian law places a high value on personal autonomy, and as a result, medical treatment without consent is generally unlawful.<sup>1</sup> The situation is different, however, where a person is deemed to lack 'capacity'. This article examines how considerations of 'capacity' currently feature, at a practical level, in the regulation of involuntary (unconsented) treatment for mental illness in a small Australian jurisdiction (the Northern Territory).

Treatment for mental illness has, for many decades, been an area where the normal requirements of informed consent do not apply. For much of the 20<sup>th</sup> century, treatment without consent was justified on the basis that those with mental illness lacked 'sound mind' – which was considered the threshold requirement for informed consent.<sup>2</sup> In more recent decades, this status-based approach to decision-making ability has given way to a cognitive approach focused on individual assessment, with 'capacity' replacing 'sound mind' as the threshold requirement for informed consent.<sup>3</sup> The corollary to this, is that *lack* of capacity has become a key part of the justification for providing treatment *without* consent.

Over the past 18 years, the Convention on the Rights of Persons with Disabilities (CRPD) has called into question the validity of 'lack of capacity' as a legal justification for treatment without consent.<sup>4</sup> Article 12(2) of the CRPD calls on parties to recognise people with disabilities as enjoying 'legal capacity on an equal basis with others', while Article 12(3) calls for people with disabilities to be provided 'the support they may require in exercising their legal capacity'. In this way, the CRPD attempts to de-couple the principle of informed consent from assessments of individual decision-making ability, effectively insisting that everyone should have the right to decide, regardless of decision-making ability, and that 'support' should be provided to enable this.<sup>5</sup>

There has been continuing debate about the practical implications of Article 12, and whether compliance can be achieved while retaining a role for substituted decision-making. The Australian Government has previously argued there is still a (limited) place for substituted decision-making.<sup>6</sup> This argument rests on interpreting the phrase 'all measures that relate to the exercise of legal capacity' in Article 12(4) as including

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<sup>1</sup> *Rogers v Whitaker* (1992) 175 CLR 479; *Department of Health & Community Services v JWB & SMB* (1992) 175 CLR 218; *Hunter and New England Area Health Service v A by his Tutor T* (2009) 74 NSWLR 88.

<sup>2</sup> Penelope Weller, 'Towards a Genealogy of "Coercive Care"' in *Coercive Care: Rights, Law and Policy* (Routledge, 2013) 15, 22–23.

<sup>3</sup> *Ibid* 24.

<sup>4</sup> *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008). Australia ratified the CRPD on 17 July 2008.

<sup>5</sup> Sascha Callaghan and Christopher James Ryan, 'An Evolving Revolution: Evaluating Australia's Compliance with the Convention on the Rights of Persons with Disabilities in Mental Health Law' (2016) 39(2) *UNSW Law Journal* 596, 602.

<sup>6</sup> See Australia's interpretative declaration to this effect: Australia, *Declarations and Reservations under the Convention on the Rights of Persons with Disabilities* (Instrument of Ratification, 17 July 2008), available online at [https://treaties.un.org/pages/ViewDetails.aspx?chapter=4&clang=en&mtmsg\\_no=IV-15&src=IND#EndDec](https://treaties.un.org/pages/ViewDetails.aspx?chapter=4&clang=en&mtmsg_no=IV-15&src=IND#EndDec).



substituted decision-making measures. Others, including the Committee administering the Convention, have taken an absolutist approach, arguing that upholding universal capacity requires that decision-making ability never be removed. The Committee has called for the repeal of all legislation enabling involuntary mental health treatment,<sup>7</sup> and an interpretation of Article 12 that wholly rejects the use of functional capacity tests justifying substituted decision-making.<sup>8</sup>

Australian jurisdictions which have undertaken mental health law reform following the CRPD have tended to take a moderate, pragmatic approach — rejecting absolutist approaches and enlarging the scope for ‘supported decision-making’ (to varying degrees) while allowing for involuntary (unconsented) treatment in limited circumstances.<sup>9</sup> Relevantly, every Australian jurisdiction currently treats capacity considerations as relevant to decisions about involuntary treatment, although not all jurisdictions include capacity considerations in the core criteria for involuntary treatment.<sup>10</sup> A comparative view of legislative provisions across the Australian states and territories can be found at Appendix A.

The Northern Territory (NT) of Australia has been undertaking a multi-year review of its mental health legislation. While the review process has been incredibly protracted, the expectation is that the NT Government will soon introduce legislation in similar terms to the *Mental Health Bill* released as an Exposure Draft in 2024. The NT will then become the last Australian jurisdiction to review and reform its legislation following the CRPD. Like other Australian jurisdictions, the NT currently includes consideration of capacity in its legislative criteria for involuntary treatment. However, the current NT legislation is unique in not prescribing what constitutes capacity, and in not indicating what factors are relevant (or not relevant) to the assessment. The pre-reform context in the NT therefore provides a unique opportunity for study into how the concept of capacity is understood and operationalised when there is no legislative guidance.

This article presents findings from a small research study examining capacity discourse in the NT using data drawn from existing caselaw and an in-depth interview with a psychiatric practitioner. While the dataset is limited, it provides a useful starting point for understanding how the concept of capacity is interpreted in decisions made under the current NT legislation.

*Parts 1-3* provide the contextual backdrop for the study. In Part 1, I highlight how ‘capacity’ has been constructed through the common law and in legislation. In Part 2,

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<sup>7</sup> Committee on the Rights of Persons with Disabilities, *General Concluding Observations on the Initial Report of Australia*, 10<sup>th</sup> sess, 118<sup>th</sup> mts, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) 5[34].

<sup>8</sup> Committee on the Rights of Persons with Disabilities, *General Comment No 1, Article 12: Equal Recognition before the Law*, 11<sup>th</sup> sess, UN Doc CRPD/C/GC/1 (19 May 2014), [15].

<sup>9</sup> See Callaghan and Ryan (n 5), noting this doesn’t factor in recent South Australian and Victorian reforms.

<sup>10</sup> *Mental Health and Related Services Act 1998 (NT)* s 14(c) (‘NT Act’); *Mental Health Act 2009 (SA)* s 21(1)(ba) (‘SA Act’); *Mental Health Act 2013 (Tas)* s 40(e) (‘TAS Act’); *Mental Health Act 2014 (WA)* s 25(1)(c) (‘WA Act’); *Mental Health Act 2015 (ACT)* s 58(2)(b) (‘ACT Act’); *Mental Health Act 2016 (Qld)* s 12(b) (‘Qld Act’); *Mental Health and Wellbeing Act 2022 (Vic)* s 89(1)(a) (‘VIC Act’); *Mental Health Act 2007 (NSW)* s 68(h1) (‘NSW Act’).

I highlight how questions of capacity fit into NT legislation and the role they play in the regulation of involuntary treatment. I consider points of similarity and difference with mental health legislation in other Australian jurisdictions. In Part 3, I provide a brief review of some relevant literature.

*Parts 4-6* highlight the study's findings on how the concept of capacity is understood and operationalized by those applying current NT legislation. How is it constructed? What is the normative basis for decisions that a person lacks capacity? What evidence or markers are used to establish a lack of capacity? How do medical and legal constructions of capacity differ? How are differences resolved by the Tribunal? In Part 4, I analyse discourse about capacity in the key NT case, and highlight the need for empirical research that goes beyond 'the law on the books'. In Part 5, I share and analyse pilot data from a semi-structured qualitative interview conducted with a medical practitioner. In Part 6, I highlight how the findings of this study support the case for legislative reform.

### STATEMENT OF POSITIONALITY

From 2017-2019, I worked as a lawyer representing individuals in hearings before the Mental Health Review Tribunal, which is now part of the Northern Territory Civil and Administrative Tribunal (NTCAT) (hereafter, the Tribunal). Through this work, I became aware (at a general level) of differences between legal and clinical approaches to capacity. While my colleagues and I approached capacity through the lens of functional common law tests, the doctors ('authorised psychiatric practitioners') who appeared in the Tribunal seemed to approach capacity differently. The concept of 'insight' came up regularly – a concept that does not feature expressly in NT mental health legislation, or any other Australian mental health legislation.

During this work, I was also struck by the lack of transparency and accountability surrounding decision-making about whether a person could be treated without consent. Tribunal review proceedings were closed to the public, and few decisions were ever published or given scrutiny via an appeals process. This was due to multiple factors, both legal and practical. There was the need to identify legal error without written reasons (which I discuss further on). There were also considerable practical obstacles to obtaining instructions to file an urgent injunction from a person involuntarily detained. And while appeals on behalf of those treated involuntarily in community were more practicable, the wheels of justice turned very slowly. In the case of *AX v Mental Health Review Tribunal & Anor* (in which I was involved),<sup>11</sup> the Supreme Court handed down its decision over 11 months after the Tribunal's original decision to order involuntary treatment. For all these reasons, appeals did not provide a satisfactory solution to the lack of transparency I encountered.

It is now over six years since I was a participant in NT mental health tribunal proceedings. I have moved 'down south' (as the Darwin locals say) and into other, unrelated roles. The passing of time has sharpened my awareness of how difficult it is for those on the outside (which now includes me) to find out how decisions about

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<sup>11</sup> [2019] NTSC 34.

involuntary mental health treatment are made in practice. The research presented in this paper was motivated by a desire to provide some of this missing information, for the benefit of those considering legislative reform.

## PART 1: CAPACITY ASSESSMENTS IN CONTEXT

I begin with a brief analysis of how the concept of ‘capacity’ has been interpreted and constructed in legal discourses – specifically, in the common law<sup>12</sup> and in contemporary Australian mental health legislation. This will provide some points of comparison for when we look, later, at how capacity is interpreted by medical practitioners and Tribunal members in the NT.

### *A. Capacity is presumed unless there is evidence to the contrary.*

The common law has recognised a rebuttable presumption of capacity that applies in the context of all decisions about medical treatment.<sup>13</sup> Underlying this presumption is a rejection of the older, status-based approach to capacity. As Bell J said in the Victorian Supreme Court case of *PBU*: ‘a person does not lose the benefit of the presumption of capacity upon the basis of their status as a person with a mental disability’.<sup>14</sup>

Most Australian states and territories (although not the NT) have now codified the common law *presumption* of capacity in their mental health legislation,<sup>15</sup> although legislation in these jurisdictions does not necessarily reflect the common law approach as a whole. For example, while the ACT and Victoria include a presumption of capacity in their mental health legislation, they also allow for substituted decision-making in some situations where a person has capacity but is refusing treatment.<sup>16</sup>

Relevantly, courts have found that where a party seeks to rebut the presumption of capacity in the context of involuntary mental health treatment, the standard of proof set out in the High Court case of *Briginshaw*<sup>17</sup> applies.<sup>18</sup> That is, the evidence must be ‘clear, compelling and of high probative value’, because a finding that a person lacks capacity would produce grave or adverse consequences.<sup>19</sup>

### *B. Capacity is defined in ‘functional’ terms.*

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<sup>12</sup> For the benefit of readers who are not from this tradition, the common law system involves judges developing the law on a case-by-case basis, building on the reasoning and interpretation contained within earlier decisions by superior courts. In Australia, legislation operates in tandem with the common law. Tribunals are bound by the decisions of courts on the meaning of legislation that is within their jurisdiction. The NT Tribunal then, when it decides mental health matters, is bound by NT judicial decisions on the interpretation of NT mental health legislation. Other cases (for example, by courts of another state or territory) may be persuasive but are not binding.

<sup>13</sup> *Re MB* (1997) 2 FLR 426, 436, cited with approval in *Hunter* (n 1) [23].

<sup>14</sup> *PBU & NJE v Mental Health Tribunal and Others* (2018) 56 VR 141 (*‘PBU’*) [145].

<sup>15</sup> See: *ACT Act* (n 10) s 8(1)(a); *Qld Act* (n 10) s 5(b); *TAS Act* (n 10) s 7; *VIC Act* (n 10) s 85; *WA Act* (n 10) s 13(1); *SA Act* (n 10) s 5A.

<sup>16</sup> See *ACT Act* (n 10), s 58(2); *VIC Act* (n 10) s 89(1)(a).

<sup>17</sup> *Briginshaw v Briginshaw* (1938) 60 CLR 336 (*‘Briginshaw’*).

<sup>18</sup> *AX v Mental Health Review Tribunal & Anor* (2019) NTSC 34 (*‘AX’*) [33]; *PBU* (n 14) 207 [206].

<sup>19</sup> *Ibid* [33].

In the common law we also see capacity constructed as a 'functional test' (looking at decision-making ability), rather than an 'outcome-focused test' (looking at the content of the decision and how it aligns with prior decisions or social norms).<sup>20</sup> In *Hunter*, McDougall J focused attention on 'the ability of the person to receive, retain and process information that bears on the decision'.<sup>21</sup> In *Heart of England NHS Foundation Trust*, Jackson J stated:

The temptation to base a judgment of a person's capacity upon whether they seem to have made a good or bad decision, and in particular upon whether they have accepted or rejected medical advice, is absolutely to be avoided.<sup>22</sup>

Consistent with the functional approach, capacity has also been interpreted in the common law as 'issue specific',<sup>23</sup> and temporal.<sup>24</sup> The issue-specific notion stems from discourse that constructs capacity as existing on a continuum, with some decisions requiring a higher degree of capacity than others. As MacDougall J highlighted in *Hunter*, making a decision to buy a cup of coffee does not require the same degree of capacity as making the ('more important') decision 'to give away one's fortune'.<sup>25</sup>

The 'functional' approach is reflected in the mental health legislation of most Australian states and territories. Those statutes that *define* capacity generally define it in terms of whether a person can do the following four things: (1) 'understand' the information relevant to a decision (2) 'retain' or remember the information (3) 'use' (or 'weigh') the information, or both, in making a decision and (4) 'communicate' the decision.<sup>26</sup> Many jurisdictions have also included, in their legislation, guidance which reflects a functional approach. They might have provisions that construct capacity as time-specific and issue-specific, or that explicitly reject an outcome-focused approach (looking at whether the decision is consistent with recommendations, or whether it is wise).<sup>27</sup>

### *C. Insight is relevant, but not determinative.*

Finally, it is worth drawing attention to how the common law has interpreted the relationship between capacity and the psychiatric concept of 'insight'.

While 'insight' does not have a consistent definition within psychiatry, there are some approaches to definition that have been influential. One is Lewis' 1930s definition of insight as 'a correct attitude towards a morbid change of self'.<sup>28</sup> Another is David's

<sup>20</sup> Bernadette McSherry, 'Legal Capacity under the Convention on the Rights of Persons with Disabilities' (2012) 20 *Journal of Law and Medicine* 22, 24.

<sup>21</sup> *Hunter* (n 1) [40].

<sup>22</sup> [2014] EWHC 342 (COP); cited in *PBU* (n 14) [171].

<sup>23</sup> *Re S* [2010] 1 WLR 1082, 1094 [53] (Judge Hazel Marshall QC); cited in *PBU* (n 14) [148].

<sup>24</sup> *Re N* [2017] 2 WLR 1011, 1022 [25]; cited in *PBU* (n 14) [149].

<sup>25</sup> See *Hunter* (n 1) [24].

<sup>26</sup> See: *VIC Act* (n 10) s 87; *SA Act* (n 10) s 5A; *ACT Act* (n 10) s 7; *WA Act* (n 10) s 15(1); *TAS Act* (n 10) s 7(1); *Qld Act* (n 10) s 14(1).

<sup>27</sup> See: *VIC Act* (n 10) ss 85(2), 87; *SA Act* (n 10) s 5A; *ACT Act* (n 10) s 8; *Qld Act* (n 10) s 14(2).

<sup>28</sup> Aubrey Lewis, 'The Psychopathology of Insight' (1934) 14(4) *British Journal of Psychiatry* 332; for discussion of influence, see Paula Case, 'Dangerous Liaisons? Psychiatry and Law in the Court of

1990 definition. David defined insight as having three characteristics: recognition of mental illness, compliance with treatment, and the ability to relabel unusual events as pathological.<sup>29</sup>

The Victorian case of *PBU* (while not binding on courts in the NT) is worth mentioning as a rare example of an Australian superior court considering the relevance of insight in the context of capacity assessments.<sup>30</sup> In the context of applying the Victorian mental health legislation, Bell J found that insight into illness and need for treatment was relevant as a factual consideration, but not as a normative criterion for capacity.<sup>31</sup> Thus, a person who lacks insight may also lack capacity, but it does not follow that they *must* be lacking capacity.<sup>32</sup> Insight, according to this case, is not determinative of capacity.<sup>33</sup>

In Part 2, I will highlight how the concept of capacity features in current NT mental health legislation.

## PART 2: THE NORTHERN TERRITORY LEGISLATIVE FRAMEWORK

In the NT, involuntary mental health treatment is currently regulated by the *Mental Health and Related Services Act 1998* (the NT Act). The NT Act provides that a person can be treated on an 'involuntary' basis (without their consent) if certain criteria are met. These are set out in s 14:

- (a) the person has a mental illness; and
- (b) as a result of the mental illness:
  - i. the person requires treatment that is available at an approved treatment facility; and
  - ii. without the treatment, the person is likely to:
    - A. cause serious harm to himself or herself or to someone else; or
    - B. suffer serious mental or physical deterioration; and
  - iii. the person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment; and
- (c) there is no less restrictive means of ensuring that the person receives the treatment.<sup>34</sup>

### *A. Capacity is a key consideration*

There are two legal justifications for involuntary treatment at work in the NT Act. In s 14(b)(i) and (ii), involuntary treatment is justified by reference to harms that may result if a person does not receive treatment. In s 14(b)(iii), involuntary treatment is justified by reference to *lack of consent*; either the person does not have capacity to provide consent or, they do have capacity, but are 'unreasonably' refusing to consent.

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Protection - Expert Discourses of "Insight" (and 'Compliance') (2016) 24(3) *Medical Law Review* 360, 366.

<sup>29</sup> A David, 'Insight and Psychosis' (1990) 156(6) *British Journal of Psychiatry* 798; for discussion of influence, see Ivana Markova, *Insight in Psychiatry* (Cambridge University Press, 2005) 71.

<sup>30</sup> *PBU* (n 14).

<sup>31</sup> *Ibid* [191], [206].

<sup>32</sup> *Ibid* [193], [198].

<sup>33</sup> *Ibid* [194].

<sup>34</sup> *NT Act* (n 10), s 14. See also s 16 which sets out similar criteria for involuntary treatment in the community.

While the *lack of consent* criterion can be met by establishing either 'lack of capacity' or 'unreasonable refusal', capacity needs to be assessed in every case. Capacity assessments then, are a key part of the regulation of involuntary treatment for mental illness.

### *B. Guidance around interpretation of capacity*

The NT Act is marked by a lack of clarity when it comes to the concept of 'capacity'. Strikingly, of the seven Australian jurisdictions that include consideration of capacity in the criteria for involuntary treatment,<sup>35</sup> the NT is the *only* jurisdiction that has not (yet) provided guidance on what constitutes capacity, and how it should be assessed. In contrast to other jurisdictions, the current NT Act does not provide:

- a definition of capacity; or
- a presumption in favour of capacity; or
- relevant considerations/principles that apply when assessing capacity; or
- confirmation of whether a person can be deemed to lack capacity based on the content of a decision (eg. whether it is wise, whether it is consistent with recommendations); or
- an indication of whether capacity assessments can take account of what the person can do with assistance (the supported decision-making approach).

As a result, the meaning of 'capacity' is currently left for those implementing the legislation to resolve.

Included, at Appendix A, is a table providing a comparative view of the approach to capacity across different Australian jurisdictions.

### *C. Who makes decisions?*

Under the current NT Act, decisions about whether a person meets the criteria for involuntary treatment are made by two distinct groups of people: medical clinicians, and in particular 'authorised psychiatric practitioners' (APPs); and members of the Northern Territory Civil and Administrative Tribunal (the Tribunal), acting in a review capacity.<sup>36</sup>

Initially, it is clinicians who make the assessments and authorise involuntary treatment for mental illness. Decisions are made at two key intervals. At the first interval, a clinician makes a preliminary decision about whether a person meets the criteria for involuntary treatment under the Act.<sup>37</sup> If the clinician assesses that the person *does* meet the criteria, that compels a formal examination and assessment by an APP.<sup>38</sup> However, the practical effects go well beyond this. The preliminary decision can have the effect of authorising transfer to and/or detention at an approved treatment facility

<sup>35</sup> See: *NT Act* (n 10), s 14(c); *SA Act* (n 10), s 21(1)(ba); *TAS Act* (n 10), s 40(e); *WA Act* (n 10), s 25(1)©; *ACT Act* (n 10), s 58(2)(b); *Qld Act* (n 10), s 12(b); *VIC Act* (n 10), s 89(1)(a).

<sup>36</sup> The Tribunal deciding matters under the NT Act is constituted by a Legal Member, a Medical Member and a Community Member.

<sup>37</sup> *NT Act* (n 10), ss 32(4), 33 (in community); s 30(1) (in hospital).

<sup>38</sup> *Ibid* ss 34(1), 38(1).

or hospital, administration of a narrow range of treatment, and detention for a period of up to 24 hours.<sup>39</sup>

At the second interval, the APP examines and assesses the person, and makes a further assessment of whether the person meets the criteria for involuntary treatment, either in hospital or in the community.<sup>40</sup> In both cases, an assessment by the APP that a person *does* meet treatment criteria has the effect of authorising a range of treatment without consent for a period of up to 14 days.<sup>41</sup>

The Tribunal becomes involved if clinicians assess, after two weeks have expired, that longer term involuntary treatment is required.<sup>42</sup> Such treatment must then be approved by the Tribunal. If the Tribunal finds criteria for involuntary treatment in hospital are met, it can order involuntary admission for up to 3 months.<sup>43</sup> If the Tribunal finds that criteria for involuntary treatment in the community are met, it can make a Community Management Order (CMO) for a period of up to 6 months.<sup>44</sup>

It follows that if we want to know how the concept of capacity is currently understood and applied in practice, we need to look at the interpretative and decision-making practices of the Tribunal and of those clinicians who are making capacity assessments outside the Tribunal.

### PART 3: EXISTING LITERATURE ON HOW CAPACITY IS ASSESSED IN PRACTICE

There is currently only a slim body of Australian work that explores *how* capacity is assessed in decision-making under mental health legislation. In recent years, as focus has shifted to supported decision-making, this matter has received almost no attention in Australian academic quarters.

One exception is a recent Queensland study which investigated mental health clinicians' perspectives on reasons for the rise in involuntary treatment.<sup>45</sup> While the study did not focus solely on decision-making about capacity, it made a number of interesting findings relevant to this topic. Researchers found clinicians regarded capacity as vague and open to interpretation, thought emphasis on 'stability of capacity' provided a 'free pass' for involuntary treatment, and had the impression that capacity could be implicated where patient's views differed from those of the treating team.<sup>46</sup>

Going back a bit, we find several smaller Australian studies that have looked at Tribunal decision-making about capacity through the lens of published decisions in the

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<sup>39</sup> Ibid s 34(3).

<sup>40</sup> Ibid ss 38 (2)(a), 38(2)(c)

<sup>41</sup> Ibid ss 39(1)(b), 45(3)-(4), 55(2).

<sup>42</sup> Ibid ss 123(1)(a), (2).

<sup>43</sup> Ibid s 123(5)(a).

<sup>44</sup> Ibid s 123(5)(c).

<sup>45</sup> Kimballi Wild et al, 'Reasons behind the Rise in Involuntary Psychiatric Treatment under Mental Health Act 2016, Queensland, Australia – Clinician Perspectives' (2025) 98 *International Journal of Law and Psychiatry* 102061.

<sup>46</sup> Ibid 4.

state of Victoria. In their study of decisions between 2015-2016, Maylea and Ryan found that when considering decision-making capacity under the former *Mental Health Act 2014* (Vic), the Victorian Tribunal regularly linked capacity to consent with a person's compliance with proposed treatment, and treated 'insight' as a precursor to capacity.<sup>47</sup> In a 2010 chapter, Freckelton highlighted 'insight' and 'compliance' as among the extra-legislative labels used by clinicians and mental health tribunals in their decision-making, and drew on decisions of the Victorian tribunal to illustrate this.<sup>48</sup> The tendency of tribunals to rely on de facto criteria was also reported in a study involving mental health duty lawyers in Victoria, together with a tendency to defer to clinical opinion.<sup>49</sup> In a much earlier study, looking at published Victorian decisions from 1997-1998, Diesfeld and Sjostrom found that 'insight' was frequently raised in cases, especially those involving consideration of whether the person had refused or was unable to consent to treatment, but also in connection with issues of compliance.<sup>50</sup>

In addition to the small studies highlighted above, there is also the 2011 monograph by Carney *et al*, which examined the operations of three mental health tribunals in Australia (in NSW, Victoria and the ACT). While the study did not include a strong focus on issues of capacity, it did find evidence of a tendency (by psychiatrists and Tribunal members) to treat denials of mental illness as indicative of a lack of 'insight', and to use the psychiatric concept of insight as a substitute for engaging with the question of capacity.<sup>51</sup>

The findings of these Australian studies accord with the findings of other studies from the UK, Sweden and New Zealand. Three specific themes about the role of 'insight' in decision-making about capacity can be drawn from these international studies. Firstly, there is a large body of literature which highlights that 'insight', while not typically mentioned in mental health legislation, is relied on extensively in decision-making about capacity (and other criteria) under mental health legislation.<sup>52</sup> Secondly, studies

<sup>47</sup> Christopher Maylea and Christopher James Ryan, 'Decision-Making Capacity and the Victorian Mental Health Tribunal' (2018) 2017(24) *International Journal of Mental Health and Capacity Law* 87.

<sup>48</sup> Ian Freckelton 'Extra-Legislative Factors in Involuntary Status Decision-Making' in *Rethinking Rights-Based Mental Health Laws* (Hart Publishing, 2010) 203.

<sup>49</sup> Eleanore Fritze, 'The Variable Treatment of (in)Capacity in the Practical Operation of Victoria's Key Substituted Decision-Making Regimes: View from the Frontline' in *Critical Perspectives on Coercive Interventions* (Routledge, 2018) 65, 80.

<sup>50</sup> Kate Diesfeld and Stefan Sjostrom, 'Interpretive Flexibility: Why Doesn't Insight Incite Controversy in Mental Health Law?' (2007) 25 *Behavioral Sciences and the Law* 85.

<sup>51</sup> Terry Carney et al, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection & Treatment?* (Law and Justice Foundation, Themis Press, 2011) 200, 205, 302.

<sup>52</sup> Magdalena Furgalska, "'Informed Consent Is a Bit of a Joke to Me": Lived Experiences of Insight, Coercion, and Capabilities in Mental Health Care Settings' (2023) *International Journal of Law in Context* 1; Sándor Gurbai, Emily Fitton and Wayne Martin, 'Insight under Scrutiny in the Court of Protection: A Case Law Survey' (2020) 11(Article 560329) *Frontiers in Psychiatry* 1; Susanna Radovic, Lena Eriksson and Moa Kindström Dahlin, 'Absence of Insight as a Catch-All Extra-Legislative Factor in Swedish Mental Health Law Proceedings' (2020) 27(4) *Psychiatry, Psychology and Law* 601; Case (n 28). The same theme was highlighted in older studies, see for example: Elizabeth Perkins, *Decision-Making in Mental Health Review Tribunals* (London Policy Studies Institute, University of Westminster, 2003); Stefan Sjostrom, *Party or Patient? Discursive Practices Relating to Coercion in Psychiatric and Legal Settings* (Borea Bokforlag, 1997); Jill Peay, *Tribunals on Trial: A Study of Decision-Making under the Mental Health Act 1983* (Clarendon Press, 1989).

have highlighted ambiguity (or ‘flexibility’)<sup>53</sup> in the meaning of ‘insight’. While regularly used in decision-making under mental health legislation, the term is generally left undefined.<sup>54</sup> Thirdly, studies have highlighted the various functional uses of ‘insight’ in decision-making under mental health law: as a proxy or shorthand for legislative criteria;<sup>55</sup> to undermine the patient perspective and endorse medical authority,<sup>56</sup> and as a tool for assessing likely compliance with treatment.<sup>57</sup>

In Parts 4 and 5, I discuss the recent mixed methods study done in the NT, and the extent to which the findings of my study resonate with the Australian and international literature highlighted above. Clearly the body of Australian research on how capacity is interpreted and operationalised under mental health law is thin and, for the most part, dated. My study stands to make a small but valuable contribution to the existing literature. Relevantly, it is unique in its focus on the NT. The study also provides some indications of how decisions about capacity are made in practice. Further, it highlights how qualitative interviews with medical practitioners can yield rich information about this.

#### PART 4: DISCOURSE ANALYSIS OF NORTHERN TERRITORY CASELAW

The Foucauldian concept of ‘discourse’ is used across disciplines to draw attention to the way that language is used to create meaning, to structure knowledge and to create or reinforce relationships of power.<sup>58</sup> Drawing on Foucault, Norman Fairclough has defined discourse analysis as a process of analysing language, with a view to its social effects.<sup>59</sup> In Parts 4 and 5 of this article, I draw on this social-theoretical form of discourse analysis,<sup>60</sup> to study how various actors (in particular, Tribunal members and APPs) use language to constitute and construct ‘capacity’ when making decisions under mental health legislation. My aim is not to provide a normative assessment of whether the approach of various actors is correct, but rather to call attention to what various discourses reveal about how the concept of capacity is being interpreted and deployed in practice.

In Part 2 I highlighted the lack of prescription in the NT Act around what capacity is, and how it should be assessed. In Part 4, I draw on NT caselaw for indications of how capacity is understood and applied in practice, and highlight the need to look beyond doctrinal sources.

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<sup>53</sup> Diesfeld and Sjostrom (n 50).

<sup>54</sup> Case (n 28); Diesfeld and Sjostrom (n 50); Kate Diesfeld and Brian McKenna, *Insight and Other Puzzles: Undefined Terms in the New Zealand Mental Health Review Tribunal* (Mental Health Commission, 2005); Perkins (n 52); Sjostrom (n 52).

<sup>55</sup> Furgalska (n 52); Carney et al (n 51); Freckelton (n 48); Perkins (n 52).

<sup>56</sup> Furgalska (n 52) 7–10; Radovic, Eriksson and Dahlin (n 52) 613–614; Case (n 28) 367; Diesfeld and Sjostrom (n 50) 97.

<sup>57</sup> Furgalska (n 52) 8–9; Case (n 28) 367; Freckelton (n 48) 213; Diesfeld and Sjostrom (n 50) 93–94; Perkins (n 52) 124.

<sup>58</sup> See eg. Michel Foucault, *The Archaeology of Knowledge and the Discourse on Language* (Pantheon, 1972).

<sup>59</sup> *Analysing Discourse: Textual Analysis for Social Research* (Routledge, 2003).

<sup>60</sup> Norman Fairclough, *Discourse and Social Change* (Polity Press, 1992) 3–4.

### *A. Doctrinal sources are limited in number*

In recent years, the Northern Territory Civil and Administrative Tribunal (the Tribunal) has dealt with an average of 724 mental health matters per year.<sup>61</sup> A large percentage of these matters result in orders for involuntary treatment (almost 50% in 2022-2023).<sup>62</sup> However, at the time of writing, there are zero published Tribunal decisions highlighting decision-making on substantive matters arising under the NT Act. This is despite the current NT Act having been in operation for over 25 years.

Judy Harrison has coined the term 'conditions of observability' to capture and frame the conditions which make legal problems observable, and actionable.<sup>63</sup> The 'conditions of observability' surrounding Tribunal decision-making on mental health matters are limited as a result of several provisions in the current NT Act. These provisions provide that: mental health hearings are closed to the public;<sup>64</sup> the general obligation to provide written reasons does not apply in mental health matters;<sup>65</sup> and if the Tribunal *does* decide to provide written reasons, it has discretion whether to publish a de-identified version of the reasons.<sup>66</sup> Further, unlike in other Australian jurisdictions like the ACT and Victoria, there is no obligation on the Tribunal to provide written reasons if requested to do so by a party to proceedings.<sup>67</sup> A person subject to Tribunal review is only entitled to an audio recording of the review proceedings.<sup>68</sup> Together, these provisions create an operating environment where the norm is for the Tribunal to provide only brief oral reasons at the conclusion of the hearing (*ex tempore*) – nothing in writing, and nothing accessible to those outside the hearing room.<sup>69</sup>

The legislative restrictions outlined above appear motivated by a desire to protect the privacy of the patient, and their health and safety.<sup>70</sup> This comes, however, at the cost of procedural justice. Without written reasons, it is significantly more difficult for a patient — and their lawyer — to know and understand the basis for the Tribunal's decision, and whether the decision involves error. This in turn bears directly on the patient's ability to appeal to the Supreme Court, because the right to a 'rehearing' provided under the current Act *depends* upon the existence of a legal, factual or discretionary error.<sup>71</sup> In short, the lack of written reasons undermines access to review, such that the right of appeal is attenuated.

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<sup>61</sup> Information obtained by the writer under the *Information Act 2002* (NT) (13 October 2023) ('*FOI Release*'); Northern Territory Civil and Administrative Tribunal, *NTCAT Annual Report 2021-2022* (2023) 10 [21].

<sup>62</sup> *FOI Release* (n 61).

<sup>63</sup> Judy Harrison, 'Conditions of Observability', *ANU School of Legal Practice* (15 September 2017) <<https://legalpractice.anu.edu.au/news-and-events/news/conditions-observability>>.

<sup>64</sup> *NT Act* (n 10), s 135(1).

<sup>65</sup> *Ibid* s 141.

<sup>66</sup> *Ibid* s 141A.

<sup>67</sup> *ACT Civil and Administrative Tribunal Act 2008*, s 60; *VIC Act* (n 10), s 380.

<sup>68</sup> *NT Act* (n 10), s 136.

<sup>69</sup> In 2022-2023, there was only one matter where a written statement of reasons was produced, and this was provided to the parties only: *FOI Release* (n 61).

<sup>70</sup> *NT Act* (n 10), ss 135(2), 145A.

<sup>71</sup> *Ibid* ss 142(1), (3); *CH v Mental Health Review Tribunal & Anor* [2017] NTSC 43 ('*CH*') [31]; affirmed in *AX* (n 18) [13] - [14].

The limited conditions of observability, created by the legislation, also impede public understanding of the interpretive and decision-making practices of clinicians. It is only when the Tribunal's decisions are appealed to the NT Supreme Court that non-participants in the Tribunal process can observe how APPs, and the Tribunal, make decisions about whether someone should be given involuntary treatment. Unsurprisingly however, given the obstacles to appeal, the data set is limited. In the whole time that the NT Act has been in operation, there have (at the time of writing) been only eleven Supreme Court decisions involving appeals of Tribunal decisions under the NT Act.

### *B. Capacity discourse in Supreme Court appeal decisions*

Of the eleven NT Supreme Court decisions that involve appeals of Tribunal decisions under mental health legislation, only one case addresses questions of capacity in any detail: *AX v Mental Health Review Tribunal & Anor* (2019) 34 NTSC. A further five cases address capacity issues only in passing.<sup>72</sup>

The paucity of Supreme Court decisions (combined with the lack of published Tribunal decisions) means that, to gain a deeper understanding how capacity is being interpreted and operationalised in practice, we need to go beyond the 'law on the books'. In the section below, I highlight what we can draw from the case of *AX*, before moving on to analyse pilot data from an interview with an APP.

### *C. AX v Mental Health Review Tribunal & Anor*

As the only NT case that addresses issues of capacity in detail, the case of *AX* provides the best indication of how capacity is interpreted and operationalised in the NT context. The Supreme Court in that case was required to consider whether, based on the evidence, it was open to the Tribunal to find that the appellant lacked capacity to provide informed consent to treatment. It is because the Supreme Court refers in detail to the Tribunal transcript, that we can get a glimpse of how capacity was interpreted and operationalised by those involved in the Tribunal proceedings.

By analysing the Tribunal transcript (excerpted in the Supreme Court judgment) we can see how the duty lawyer, the APP and the Tribunal seemed to understand and operationalise the concept of capacity.<sup>73</sup>

#### *(i) The duty lawyer's approach*

There is a passage in the Tribunal transcript (cited by the Supreme Court) where the duty lawyer leads evidence from *AX*, taking an approach that aligns with common law

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<sup>72</sup> See *CLM v Northern Territory Civil and Administrative Tribunal & Ors* [2025] NTSC 12 at [38]; *EJ v Mental Health Review Tribunal & Anor* [2024] NTSC 47 at [30]; *ET v The Northern Territory of Australia* [2022] NTSC 94 at [10], [13], [15]; *CH* (n 71) at [14]; *KMD v the Mental Health Review Tribunal & Anor* [2020] NTSC 13 at [16]–[17].

<sup>73</sup> In the interests of full disclosure, I note that I (the writer) was the duty lawyer in this case, and the instructing solicitor in the Supreme Court appeal.

discourse about capacity. First, the lawyer highlights that AX understands information relevant to the decision (about treatment) and has retained it.<sup>74</sup>

HQ: So, [AX], do you think you have a mental illness?

AX: Yes.

HQ: And what is it, does it have a name?

AX: Schizo-affective bipolar.

HQ: And do you think you need medication for that illness?

AX: Yes.

HQ: What happens if you don't have medication for it?

AX: I'll be sick.

[...]

HQ: And how do you remember to take the tablets?

AX: I set my alarm on the phone.

HQ: You set your alarm, okay. And do you think the medication helps you?

AX: Yes.

HQ: How does it help you?

AX: It makes me feel better, think better, do things a bit better, and functions a bit better.

Then, the lawyer highlights that AX can *use or weigh* the information: <sup>75</sup>

HQ: .... Do you have any concerns about your medication?

AX: Um, at the moment, just a bit too much I think, it's just that I get a lot of pains and sickness and all of that.

HQ: Yeah.

AX: So, but I'm putting up with it.

HQ: Yeah, and I understand you've been talking to Dr Willcocks about that?

AX: Yes.

HQ: And working with her on how to manage some of those side effects?

AX: Yes, we are.

HQ: Yeah, that's good. Are you happy to continue doing that, taking the medication and talking to Dr Willcocks?

AX: Yes. Yes.

...

The lawyer then provides an opportunity for AX to *communicate* her decision:<sup>76</sup>

HQ: Would you keep taking the medication if you were not on a CMO?

AX: Yes.

Later in the Tribunal hearing, the lawyer submitted that the test for capacity (in the criteria for involuntary treatment) 'should be interpreted as a point in time test, rather than as a longitudinal test involving speculation about what will happen in the future'.<sup>77</sup>

## *(ii) The APP's approach*

<sup>74</sup> AX (n 18) [29] (citing Tribunal transcript).

<sup>75</sup> Ibid.

<sup>76</sup> Ibid.

<sup>77</sup> Ibid [46].

AX's psychiatrist (APP) takes a different approach to assessing capacity. The APP had submitted, in her report to the Tribunal, that AX was not capable of providing informed consent to treatment because:

[AX] continues to attribute her symptoms to 'nervous breakdowns' and has poor insight evidenced by nonadherence to medications.<sup>78</sup>

In the tribunal hearing, the APP then gives the following additional evidence about compliance:

We know that when AX has come into hospital unwell, we know that generally she has told us that she's not been fully compliant. I think generally when she's well, she's compliant. I wonder if something, you know, makes you start becoming unwell and then the change in thinking is what then leads to some non-compliance....

I don't think you deliberately go off it, you know, all the time...<sup>79</sup>

These excerpts from the APP's evidence, highlighted in the Supreme Court decision, reveal four things about how the APP understood and assessed capacity. First, they reveal that for this APP, insight was the normative consideration underlying the capacity assessment. Second, insight comprises (at least) two elements: insight into illness, and insight into the need for treatment. Third, insight is related to compliance. Non-compliance is presented, in the APP's written report (cited above), as indicative of a lack of insight (*'poor insight evidenced by nonadherence to medications'*). Further, while the logic behind the APP's oral evidence is somewhat opaque, there seems to be a suggestion that lack of insight (through a 'change in thinking') causes non-compliance. This is consistent with Diesfeld and Sjostrom's study, which found a mutually reinforcing relationship between insight and compliance in published Victorian decisions.<sup>80</sup>

### *(iii) The Tribunal's approach*

It is instructive to see how the Tribunal, considering AX's matter, responds to the competing legal and clinical discourses about capacity that surfaced during the hearing. In delivering the Tribunal's decision, the Legal Member of the Tribunal starts by saying:

We have listened very carefully.... But right now we're not accepting that you have the sort of insight that is necessary that would give us the confidence not to make a CMO [Community Management Order] today. We certainly believe that you have a degree of insight, but we think that at times that changes.<sup>81</sup>

After explaining that the Tribunal is satisfied that AX had a mental illness, requires treatment, and without treatment would suffer a serious mental or physical deterioration, the Legal Member concludes:

... right now you are not capable of giving the informed consent that is required. There are times where we think you've reached it, but there are times very recently where it hasn't as well. It

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<sup>78</sup> Ibid [25].

<sup>79</sup> AX (n 18) [31] (citing Tribunal transcript).

<sup>80</sup> Diesfeld and Sjostrom (n 50) 93–94.

<sup>81</sup> AX (n 18) [32] (citing Tribunal transcript).

fluctuates. But it's not so far, your refusals, your lack of insight is not so long ago, that we accept what your lawyer has said...<sup>82</sup>

These excerpts are very revealing. They show the Tribunal adopting and, in some ways, extending the clinical constructions of capacity that had been presented. For example, the Tribunal adopts the APP's focus on insight as a central consideration when assessing capacity. The Tribunal actually seems to go further, using insight as a proxy for capacity in its reasons for decision. We see this in the way that the Legal Member moves quickly from talking about fluctuating insight, to a lack of capacity, and then back to fluctuating insight. This resonates with studies from both Australia and the UK that have found evidence of insight being used as a 'shorthand', or 'rule of thumb' substituting for actual legislative criteria.<sup>83</sup>

Functionally, the concept of insight provides a basis on which the Tribunal can reject other evidence that may suggest the patient has capacity, and thereby reconcile the competing accounts of the patient and her treating doctor. This echoes other studies that have highlighted the use of insight to undermine counter perspectives,<sup>84</sup> to minimise the scope for disagreement,<sup>85</sup> and to pathologise patient perspectives.<sup>86</sup>

In the case of *AX*, we also see the Tribunal constructing insight/capacity as something that exists on a continuum. In the Legal Member's words, *AX* had 'a degree of insight' but not 'the sort of insight that was necessary' to satisfy the Tribunal that a CMO should not be granted.<sup>87</sup> This approach, whereby the decision-maker presents insight as existing on a continuum but does not define the grading of insight that is sufficient or necessary, has also been detected in other studies.<sup>88</sup> Diesfeld and Sjoström have suggested that it may be motivated by a desire to give assessments of insight 'the appearance of scientific objectivity'.<sup>89</sup>

The Tribunal also follows the APP in linking non-compliance back to lack of insight ('*your refusals, your lack of insight...*'). Again it goes further, linking deterioration (evidenced by admissions) back to non-compliance. The admissions were '*very very recent*', and therefore there must have been non-compliance ('refusals') '*not so long ago*'. The Tribunal's reasons for decision suggest a chain of logic whereby a lack of insight leads to non-compliance, which leads to deterioration. Further, this chain of logic seems to be applied in a way that enables the past to be used as a predictor of the future. Diesfeld, noting the use of insight as a tool for predicting future behaviour, has suggested that this use of the concept stems from concern for patient well-being; in a context where there is considerable uncertainty, decision-makers want to know whether a vulnerable person will be able to seek care when they need it.<sup>90</sup> Radovic,

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<sup>82</sup> Ibid.

<sup>83</sup> Furgalska (n 52); Carney et al (n 51); Freckelton (n 48); Perkins (n 52) 127.

<sup>84</sup> Diesfeld and Sjoström (n 50) 97.

<sup>85</sup> Furgalska (n 52) 7–10; Radovic, Eriksson and Dahlin (n 52) 613–614.

<sup>86</sup> Case (n 28) 367.

<sup>87</sup> *AX* (n 18) [32].

<sup>88</sup> Diesfeld and Sjoström (n 50); Diesfeld and McKenna (n 54); Gurbai, Fitton and Martin (n 52).

<sup>89</sup> Diesfeld and Sjoström (n 50) 95.

<sup>90</sup> Kate Diesfeld, 'Insight: Unpacking the Concept in Mental Health Law' (2003) 10(1) *Psychiatry, Psychology and Law* 63, 67.

who conducted interviews with professional participants in Swedish mental health court proceedings, found that interviewees considered compliance with medication a measure of 'true' insight and decisive of whether a person needed involuntary treatment.<sup>91</sup>

*(iv) The Supreme Court's approach*

As highlighted earlier, NT mental health cases rarely make it to the Supreme Court. It is APPs and Tribunals who primarily make decisions about involuntary treatment under current legislation. The Supreme Court decision in *AX* provides a useful window into the competing approaches to capacity in that case – practices that would otherwise be quite invisible. Beyond this, of course, the decision of *AX* also has precedential value: it provides guidance for future decision-making on capacity in the NT.

Before the Supreme Court, *AX*'s counsel submitted that in the context of the APP's evidence on the day of the hearing (and *AX*'s own evidence), it was not open for the Tribunal to find, to the *Briginshaw* standard, that *AX* lacked capacity to provide informed consent.<sup>92</sup> In this way, the appeal invited the Supreme Court to provide guidance on how capacity should be assessed, and which of the competing approaches from the Tribunal hearing should be preferred.

Unfortunately, the Supreme Court did not embark on a fulsome exposition of how capacity should be assessed under NT legislation, or the specific relevance of 'insight' and 'non-compliance'. The decision does seem to involve, however, a rejection of the duty lawyer's submission that capacity is a point in time test, and endorsement of a longitudinal approach. We see this in *Blokland J*'s finding that it was open for the Tribunal to reject oral evidence presented on the day of the hearing (that was favourable to the appellant) and find that *AX* *lacked* capacity, relying on the APP's written report about what had happened in the past, and information about previous admissions which was on the Tribunal's file:<sup>93</sup>

I am not persuaded the Tribunal fell into error on this point when all of the relevant material is considered. It is accepted the Tribunal appeared to rely quite heavily on the history of the appellant's treatment including previous orders. History is important and relevant in these cases, although over reliance on history may lead to unfairness. The oral evidence before the Tribunal was only part of the material relevant to the question of informed consent. [The APP's] evidence before the Tribunal, much of which may be interpreted as favourable to the appellant's case, was focussed on the appellant's appearance on the day of the hearing. She did also observe the appellant to be 'relatively stable' in the past 6 months. However, her evidence needs to be considered against the material in the Form 15 which pointed to 'fluctuating insight, erratic adherence with medications and treatment plan, and the risks *AX* is exposed to while unwell'.<sup>94</sup>

... In this matter it is the case, as submitted by the second respondent, that the Tribunal's state of satisfaction was in fact informed by...the appellant's history of non-compliance with medication,

<sup>91</sup> Radovic, Eriksson and Dahlin (n 52) 609.

<sup>92</sup> *AX* (n 18) at [35].

<sup>93</sup> *AX* (n 18) at [41]-[42].

<sup>94</sup> *AX* (n 18) at [41].

documented in the Form 15 prepared in May 2018, and the records of her previous hospital admissions.<sup>95</sup>

It is unclear from these Supreme Court findings exactly *how* and *why* a person's previous mental health history (including non-compliance and admissions) is relevant to the question of capacity. However, the leading NT decision clearly upholds a backwards-looking approach to capacity assessments and puts emphasis on patient stability over the longer term.<sup>96</sup> Further, the decision in *AX* highlights the immense difficulty that individuals who have a history of involuntary treatment may face, in demonstrating that they can now be treated on a voluntary basis.

## PART 5: DISCOURSE ANALYSIS OF THE INTERVIEW DATA

### *A. Methodology*

I turn now to highlight some data drawn from a semi-structured interview that I conducted with an Authorised Psychiatric Practitioner (APP) who was (at that time) appearing regularly before the NT Tribunal seeking involuntary treatment orders. The interview was conducted in October 2023, with approval from the Australian National University Ethics Committee<sup>97</sup> and with organisational approval from NT Health.<sup>98</sup> While the plan was originally to conduct a set of interviews, this could not be achieved within the short timeframe for the research project.<sup>99</sup> The data collected thus serves as 'pilot data' for a larger project, demonstrating how semi-structured interviews with psychiatrists can extend our understanding of how capacity is interpreted and operationalised and also, providing a practical check on the methodology.

Recruitment occurred at arms-length, with the interviewee volunteering to be a participant in the research in response to a written invitation distributed to the target group with the assistance of NT Health employees (the target group being APPs who regularly appear before the Tribunal). The interviewee signalled their willingness to participate by returning a signed written consent form by e-mail. The interview was conducted by phone, with the interviewee being asked questions relating to how they assess whether someone has capacity to consent. The interview covered topics including: the role/place of capacity assessments, working approaches to assessing capacity, markers of capacity/incapacity, the relationship between capacity and insight and the meaning of 'unreasonable refusal'. The interview was recorded, transcribed, de-identified and then analysed.

The data collected through the interview provides an interesting case study of how one APP interprets and applies the capacity test (in the NT Act) when considering the

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<sup>95</sup> *AX* (n 18) at [42].

<sup>96</sup> This resonates with findings in the recent Queensland study, see: Wild et al (n 45) 4.

<sup>97</sup> Protocol 2023/1143.

<sup>98</sup> EFILE2023/21201.

<sup>99</sup> The study was conducted within the context of the writer's LLM coursework program at the Australian National University. In the limited time between receiving relevant ethics approvals and finalizing the paper, only one interview was conducted. The reliance on potential participants taking initiative seems to have been a factor preventing the study from reaching its intended scale (of 5 interviews), but the condensed time frame for data collection likely also contributed.

need for involuntary treatment. Based on data collected through the first interview, there would be value in conducting a wider set of interviews. For this to eventuate however, the methodology would probably need to be revised to allow for more direct means of recruitment, over a longer period of time.

### *B. Analysis of interview data*

Using discourse analysis, I have drawn out seven key points of interest about the interviewee's approach to capacity. These are arranged under thematic headings (A-G) below.

#### *Theme A: Underlying the approach to capacity is a merging (or blurring) of capacity and insight*

Interestingly, when *initially* asked to define 'capacity to consent', the interviewee offered the following construction:

A1. 'I guess you would define it as the capacity to weigh up the pros and cons of treatment according to one's own values, in a way that's not unduly affected by the mental illness in question, and is able to be consistently acted on'.<sup>100</sup>

There are three elements to this construction of capacity. First, there is the framing of capacity as the ability to 'weigh' up the pros and cons of treatment. As we have seen, 'weighing' is a common element of the functional capacity tests that have been developed in the common law and reflected in mental health legislation. Secondly, in this construction, the normative standard that the exercise of the person's abilities (their 'weighing') must rise to is determined by the individual's values, not the doctor's view of what they should do. This appears to be an effort to signal that the approach to capacity is not affected by paternalistic considerations of what is in the person's 'best interests', but rather driven by the individual's internal rationality. (The interviewee went on to describe how the values must be 'part of their baseline' personality, not affected by mental illness.<sup>101</sup>) Thirdly, there is an emphasis on the need for consistency between the person's decision and their subsequent actions. This is a recurring theme in the interview data, discussed in more detail below ('Theme B').

Over the course of the interview, the interviewee's discourse about capacity evolved to reveal that underlying the surface definition of capacity initially offered (see Quote A1) are requirements of insight. For example, when asked to describe what 'indicators or markers' they look for when assessing capacity, the interviewee invoked the concept of insight, at first indirectly, then directly:

A2. (*Indirect*) Their understanding of the illness. Do they believe that they have *an* illness? Or, it doesn't even necessarily have to be conceptualized by them as an illness, but some kind of problem

<sup>100</sup> Transcript of research interview (16 October 2023) ('*Transcript*') 1.

<sup>101</sup> *Ibid.*



that requires treatment and that they have an understanding of the effect of treatment. And what effect treatment has, and what risks not having treatment would have.

*(Direct)* But I think you're also looking at the person's behavior as well, because although insight isn't directly part of capacity...Part of insight, the highest level of insight is emotional insight and below emotional insight is cognitive insight where people might have some cognitive understanding, but they're not able to act on those [understandings] necessarily. So, if a person is able to say some of the right things, but their behavior previously has indicated that they are consistently not following through on engagement with treatment, then I think you have to look at that as potentially being an indication of lack of capacity, to follow through on those decisions...<sup>102</sup>

In the second paragraph above, the interviewee conveys a theoretical understanding that capacity and insight are different ('insight isn't directly part of capacity'). But then, the interviewee's discussion about types of insight ('cognitive' vs 'emotional') leads directly to a conclusion about capacity, suggesting that in practice the concepts do blur together.

Shortly after, the interviewee seems to reconstruct their original definition of capacity as involving two questions of insight, the first involving 'cognitive'/'superficial' insight and the second involving 'emotional'/'higher level insight that drives behaviour:

A3. ...the insight has to contribute to a decision or an agreement that treatment's appropriate, which is sort of the first part of [capacity]\*, the weighing up the pros and cons of treatment. Then the next step is to be able to act on that.. Making a decision around doing something involves actually doing it... You can have insight and decide that you don't want treatment, which is slightly different – and that would be why you're not adhering... But to passively agree to treatment and then to not follow through on that - that might be due to a lack of insight, [because] there's something there, but you're not actually making that decision to do it. You're just saying something, if that makes sense...I think it is in some ways related to the concept of emotional insight – that's where it's more than just a superficial understanding of the risks and benefits. You [also] have a sort of an emotional connection - that I'm going to make an effort to do this, because I'm fearful that if I don't, then I may become unwell. Whereas if it's more of a superficial insight, when it's put to you, you can say 'yeah, I can see that I became unwell', and then when you're asked if you're going to take medication you say, 'Yeah, okay, I guess I can'. That's different from having a belief that's strong enough to actually drive behavior.<sup>103</sup>

*\*the interviewee added the content in square brackets on review of the interview transcript.*

Clearly, requirements of insight are integral to the way that the interviewee understands and operationalizes the capacity test.

### *Theme B: Capacity (insight) needs to be demonstrated by actions, not just words*

The interviewee's approach to capacity entails a striking focus on a person's actions (or behaviour) – specifically their actions in relation to recommended treatment. The effect of this is to constitute capacity in a way that is outcomes-focused and not just functional (cf legal discourses: Part 1). In the initial definition of capacity offered (see Quote A1), acting 'consistently' (with the decision produced by the 'weighing') constitutes the third element of the capacity test. In the interviewee's reconstruction of capacity as two questions of insight (see Quote A3), acting on a decision to take

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<sup>102</sup> Ibid 2.

<sup>103</sup> Ibid 2-3.

treatment is indicative of whether a person has the higher level of insight. The interviewee went on to frame 'following through' as a core component of decision-making:

B1. I mean, a decision doesn't really have any meaning if somebody doesn't follow through on it. If I say I'm going to drive down to the shops, have I really decided to drive down to the shops if I don't ever arrive at the shops? Have I made a decision to go to the shops just because I've said it? Probably not.<sup>104</sup>

These comments echo the approach of leading American psychiatrists Appelbaum and Grisso, who in a seminal paper argue that capacity requires 'the ability to maintain and communicate stable choices long enough for them to be implemented'.<sup>105</sup> A similar focus on 'following through' was observed by Radovic *et al* in their interviews with mental health court participants (in the Swedish context): 'Patients might demonstrate insight both in terms of awareness that they are ill and in terms of awareness that they need medication, but if that realization does not manifest itself as actually complying with prescribed medication, compulsory measures will need to continue'.<sup>106</sup> While not unique then, the interviewee's emphasis on 'following through' provides an angle on the insight-compliance nexus that is missing in the NT caselaw. Where the caselaw highlights only simplistic connections between insight and compliance, the interview data reveals *why* insight, compliance and capacity are so closely tied. For the interviewee, higher level (emotional) insight is what drives compliance. Thus, if a person does not follow through on what they have said, that is an indication that they lack the insight necessary to implement their reasoned decision. And if they cannot implement a decision, they cannot truly *make* a decision.

With this more detailed explanation from the interviewed APP in hand, we can perhaps better understand the evidence given by the (different) APP who appeared in the case of AX: although the patient had given evidence (at hearing) demonstrating capacity at a cognitive level, there had been 'previous times where [AX] felt concerned that she was getting side-effects and so therefore has stopped medication regimes'.<sup>107</sup> This failure to 'follow through' in the past, may have been the basis for why the APP in AX considered that, in spite of AX's evidence at the hearing, she did not have capacity to consent to treatment.<sup>108</sup>

*Theme C: Divergence from clinical recommendations is difficult to accommodate.*

There were multiple times in the interview when the interviewed APP expressed a commitment to assessing capacity in a way that did not require agreement and compliance with clinical recommendations. For example, in the initial definition of capacity (see Quote A1), the interviewee placed emphasis on the need for pros and

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<sup>104</sup> Ibid 2.

<sup>105</sup> 'Assessing Patients' Capacities to Consent to Treatment' (1988) 319(25) *New England Journal of Medicine* 1635; cited in Christopher Ryan, Sascha Callaghan and Carmelle Peisah, 'The Capacity to Refuse Psychiatric Treatment: A Guide to the Law for Clinicians and Tribunal Members' (2015) 49(4) *Australian & New Zealand Journal of Psychiatry* 324.

<sup>106</sup> Radovic, Eriksson and Dahlin (n 52) 608–609.

<sup>107</sup> AX (n 18) [35] (citing Tribunal transcript).

<sup>108</sup> Ibid [41].

cons to be weighed up according to their individual's '*own values*'. In other discussions, the interviewee signaled an openness to finding that a person who did not follow clinical recommendations could have capacity. For example, in the discussion about 'following through', the interviewee distinguished a situation where a person says they will engage with treatment but doesn't, from a situation where the person is '*not following through on it [the treatment plan], because they've got capacity, but they don't agree with treatment*'.<sup>109</sup>

Close study of the interviewee's discourse about capacity suggests that in practice, however, the interviewee's own values and assumptions do creep into their capacity assessments, making divergence from medical opinion difficult to accommodate. For example, recall that in the reconstruction of capacity as a two stage insight test (see Quote A3), the interviewee said:

'...the insight has to contribute to a decision or an agreement that treatment's appropriate'.

In this construction, there is no scope for finding that a person who disagrees that treatment is appropriate has capacity (or insight). This aligns with the focus in Lewis' definition of insight on having a '*correct attitude*', and the focus in David's definition of insight on 'compliance' (see Part 1).

Similarly, we see the interviewee's own values creeping in as they consider the relevance of what a person could do with support:

C1. Yeah, I guess if that support is effective in them being able to make *good decisions*, or sorry, make decisions, then I guess you do take that into account.<sup>110</sup> (emphasis added)

*Theme D: While relevant, the impact of support does not change the assessment of capacity*

While the interviewee indicated that the effect of support was relevant, it was seen as more relevant to the assessment of whether involuntary treatment was the least restrictive option, than to the assessment of capacity:

D1. So sometimes, even when people don't have capacity, we need to treat them in a less restrictive way. For example, if they have a really supportive person at home, or they're willing to accept treatment, even if they don't really quite understand why... There would be people who may not have...who may not meet certain criteria for having capacity, on one view, but if they have support to either make the decisions or, particularly, to follow through on those decisions, then that might make you less likely to need to involuntarily treat that person.<sup>111</sup>

Implicit in this is an individualistic approach to capacity. For the interviewee, what matters for the capacity assessment is what the individual can do alone.

*Theme E: Capacity (insight) is complex, and layered*

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<sup>109</sup> Transcript (n 100), 2.

<sup>110</sup> Ibid 5.

<sup>111</sup> Ibid.

At several points during the interview, the interviewee indicated that, in their view, questions of whether a person had insight, or capacity, were not straight-forward equations.

On 'insight', the interviewee said:

E1. it's a very complex thing, and it's not all or nothing...there's one fellow who has a six step categorization of insight, and there's insight into some things and not others. So some people might have insight into the fact that they have an illness, but not insight into the influence of medications. Or they might have insight into the illness, and the need for medication, but not other insight into the role of substances in their illness. Or they may have insight into different aspects. Or they may have insight into having an illness but lack insight into the degree of associated risk. For example, if they have been very violent in the past, they might know that there's a risk of becoming unwell, but they're underappreciating the risk that if that happens that could end up killing someone and end up in prison. So it's very complex in terms of insight, what the insight is into. You can have a degree of each aspect as well, it's very complicated.<sup>112</sup>

These comments about the variable meaning of insight, and its range of applications, resonate with the findings of other studies discussed in Part 3.

Later, the interviewee was asked to respond to the possibility of there being a definition of capacity in future legislation. The interviewee, in their response, suggested that the lack of definition around capacity and its amorphous nature was potentially helpful to clinicians applying for involuntary treatment orders:

E2. I think there's potential pros and cons to that [having a definition]. It could make it narrower and harder to argue. But I guess it could also make it easier to argue because you've got a bit of a benchmark of what you're arguing...I guess it's also not all about what's good for me to be able to argue or not!<sup>113</sup>

The interviewee went on to say:

E3. ...capacity is such a vague term, and it's certainly not black and white. Like where in the continuum of capacity do you decide that a person has it or hasn't? ... it's not a very easily definable thing.<sup>114</sup>

These comments accord with recent findings of a study involving mental health clinicians in another Australian jurisdiction (Queensland), where researchers found clinicians considered capacity a vague concept that was open to interpretation.<sup>115</sup>

#### *Theme F: What is required for capacity is relative to risk*

At another point, the interviewee suggested that the threshold level of capacity required in any given situation is relative to risk.

F1. So if the risk is that somebody might kill themselves...you're naturally going to put a high value on, or raise the threshold for, insight and being able to weigh out those pros and cons. That's

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<sup>112</sup> Ibid 3-4.

<sup>113</sup> Ibid 6.

<sup>114</sup> Ibid 7.

<sup>115</sup> Wild et al (n 45) 4.

different to where the biggest risk is that they might say something – you know, put a post on the internet that sounds silly and mildly damages their reputation.<sup>116</sup>

This application of the sliding scale of capacity is slightly different to what we see in legal discourses, where the standard of the capacity required is related more to the gravity of the *decision* that a person needs to make, rather than level of *risk* that the decision entails (see Part 1).

In Part 6, I consider what implications might be drawn from the pilot interview data.

## PART 6: WHERE TO FROM HERE?

In this article I have presented and analysed a small set of data drawn from existing NT caselaw and my own interview research. The dataset that I have relied on is clearly limited in scope; only one published decision deals with the question of capacity in any detail, and I have supplemented that decision with a single in-depth interview. Given these limitations, the dataset must be treated as indicative rather than representative. What the data presented here does, is provide a useful starting point for understanding how the concept of capacity is interpreted and operationalised by decision-makers when there is no legislative definition. In addition, the pilot interview data demonstrates the utility of qualitative interviews with medical practitioners in allowing us to 'see' and understand clinical perspectives in greater depth than what existing published decisions afford.

While the caselaw data and interview data I have presented are only indicative, what we see in them is worth highlighting:

- APPs may construct capacity differently from how capacity is constructed in the common law and in other legislation.
- APPs may understand capacity as something that is complex and amorphous.
- The concept of insight can be integral to clinical constructions of capacity and also, complex and amorphous. The concept of insight can be imported by the Tribunal into decision-making and used as a proxy for capacity.
- Compliance (or 'following through') with recommended treatment can be a key focus of clinical and Tribunal decision-making about capacity, and insight.

From a legal policy perspective, these findings provide cause for concern and support the case for legislative reform. Let me explain why.

### *A. Legislative criteria must be clear and precise*

Complex, amorphous concepts make poor legislative criteria. This is because, as Lord Diplock said, 'absence of clarity is destructive of the rule of law'.<sup>117</sup> Laws need to be

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<sup>116</sup> *Transcript* (n 100) 4.

<sup>117</sup> *Merkur Island Shipping Corporation v Laughton* [1983] 2 AC 570 at 612.

sufficiently clear to allow the public to understand their requirements, and to allow for transparency in decision-making.

The need for legal criteria to be clear and precise is particularly pronounced where satisfaction of the criteria leads to serious consequences. Under the NT Act, a finding that a person lacks capacity can be the trigger for removing a person's decision-making power and exposing them to coercive action. It is difficult to see how evidence relating to capacity could be 'clear, compelling and of high probative value' (the *Briginshaw* standard)<sup>118</sup> if the criterion itself is not clear and unambiguous. Vague concepts, or concepts like insight, with 'potential to be a portmanteau for many different components',<sup>119</sup> are an unacceptable legal basis for involuntary treatment.

### *B. The focus on compliance is problematic, especially in the NT*

We can readily understand why medical practitioners and Tribunals would take an interest in whether someone intends to accept treatment and has in the past followed treatment plans. However, the tendency to assess capacity through the lens of insight, and to assess insight based on compliance (or 'following through') is problematic on a number of levels. As Case writes, the 'compliance connection' ignores the possibility that medical practitioners, like lawyers, might sometimes be wrong.<sup>120</sup> This possibility increases where communication is impaired by cultural or language factors, or where evidence relied on is unclear. The compliance connection also leaves little room for constructive dialogue between patient and doctor about treatment options and management of side effects.<sup>121</sup> It amplifies the risk that counter perspectives will be pathologised.<sup>122</sup> And it precludes recognition of the complex and subtle factors that might cause a person to stray from the doctor's treatment plan.<sup>123</sup> For example, the side-effects of a particular medication may be intolerable.

Heavy reliance on 'compliance' in capacity assessments is also problematic in a context, such as the NT, where many patients are Indigenous. In the year 2022-2023, over 42% of those who attended mental health hearings before the NT Tribunal were identified as Aboriginal or Torres Strait Islander.<sup>124</sup> This is a large percentage and should prompt reflection on whether assessments of capacity are culturally safe. Having regard to the role that psychology and psychiatry have played in colonisation,<sup>125</sup> Indigenous people may have historically based reasons for non-compliance. Indigenous people from remote communities may also face other barriers

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<sup>118</sup> *Briginshaw* (n 17).

<sup>119</sup> Freckelton (n 48) 213.

<sup>120</sup> Case (n 28) 367; Radovic, Eriksson and Dahlin (n 52) 614.

<sup>121</sup> Ian Freckelton, 'Mental Health Review Tribunal Decision-Making: A Therapeutic Jurisprudence Lens' (2003) 10(1) *Psychiatry, Psychology and Law* 44, 55.

<sup>122</sup> Case (n 28) 367.

<sup>123</sup> Freckelton (n 121) 55.

<sup>124</sup> *FOI Release* (n 61) (16 October communication). Unfortunately, the NT data only differentiates between ATSI and non-ATSI when the patient is physically present at hearing (13 October communication).

<sup>125</sup> See Pat Dudgeon et al, 'A History of Indigenous Psychology' in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Commonwealth of Australia, 2<sup>nd</sup> ed., 2014) 39.

to engagement with treatment. Tricia Nagel has previously highlighted the foreignness of the hospital environment, the trauma associated with being transported miles from country, as well as cultural and language factors, as potential constraints on 'compliance'.<sup>126</sup>

As this discussion highlights, assessments of capacity that assume a straight-forward connection between 'compliance' and a person's understanding of illness/need for treatment carry danger. They may have an unfair, discriminatory effect on those who — for a wide range of reasons, unrelated to cognitive decision-making ability — have not followed treatment plans to the letter.

### *C. Looking to the future*

The two concerns I have outlined both relate to, or stem from, the conceptual vagueness of the term 'capacity' and the lack of guidance in the current legislation as to how it should be interpreted.

There is scope for these issues to be addressed through the legislative reform project currently underway. One answer is to provide a legislative definition of what capacity is, and guidance marking out the parameters within which assessments about capacity are to be made. In other words, to make the concept of capacity less vague and amorphous, less complex, less subjective, and less focused on compliance. Another answer, which is in keeping with the CRPD framework, is to shift the focus away from what an individual can do at an independent level, and instead look at what an individual can do with support. In other words, to expand the scope for supported decision-making — as a way of both eschewing some of the difficulties and complexities within discourse about individual decision-making capacity, and as a way of enlarging the concept of capacity itself.

In May 2024, the NT Government circulated a draft of the new mental health legislation it proposed to introduce, and sought public comment.<sup>127</sup> The Exposure Draft includes a number of positive features, such as significant legislative guidance on what decision-making capacity entails, and increased scope for supported decision-making. The draft legislation provides a presumption of capacity,<sup>128</sup> and a definition of capacity that buttresses the functional approach.<sup>129</sup> It also includes, in s 29(2), principles that must be considered when assessing capacity:

- (a) a person's decision making capacity is specific to the decision that the person is to make;
- (b) a person's decision making capacity may change over time;
- (c) a person must not be treated as not having decision making capacity unless everything practicable has been done to assist the person to make decisions, including by giving appropriate supports;
- (d) a person must not be treated as not having decision making capacity merely:
  - i. Because the person makes a decision that could be considered unwise; or

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<sup>126</sup> 'Involuntary Mental Health Treatment in the Remote Northern Territory' (2003) 10(1) *Psychiatry, Psychology and Law* 171, 174.

<sup>127</sup> *Mental Health Bill 2024 ('Exposure Draft')*.

<sup>128</sup> *Exposure Draft*, s 27.

<sup>129</sup> *Exposure Draft*, s 29.



- ii. Because of the person's age, appearance, disability, condition or behaviour.

By defining capacity, highlighting capacity as decision-specific and time-specific, and extending the concept of capacity to include what an individual can do with support, the proposed legislation (if ultimately passed) may shift some of the problematic aspects of capacity discourse that were identified in this study. Arguably, the case of *AX* would have been decided differently if the proposed provisions had been in force at that time.

Relevantly however, the draft legislation does not seem likely to reduce the need for capacity assessments. Lack of capacity remains a key prong in the criteria for involuntary treatment. Further, while the draft legislation explicitly recognises and directs attention to how the will and preferences of the individual might be expressed through formalised supported decision-making measures (eg. advance consent decisions and nominated support people), it is unclear exactly how these supported decision-making structures are intended to interact with assessments of whether involuntary treatment is justified.

How is capacity understood and operationalised by those applying NT mental health legislation? Judging by the draft legislation introduced, this is a question that will remain relevant into the future. Further research — which is clearly needed — could assess the impact of future reforms on capacity discourse, and whether the changes have any impact on the incidence of involuntary treatment.

#### APPENDIX A: COMPARATIVE TABLE OF LEGISLATIVE PROVISIONS

| Jurisdiction                                          | Criteria for involuntary treatment for mental illness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Approach to capacity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ACT:</b><br><i>Mental Health Act 2015</i><br>(ACT) | Section 58(2): The ACAT may make a psychiatric treatment order in relation to the person if—<br>(a) the person has a mental illness; and<br>(b) either—<br>(i) the person does not have decision-making capacity to consent to the treatment, care or support and refuses to receive the treatment, care or support; or<br>(ii) the person has decision-making capacity to consent to the treatment, care or support, but refuses to consent; and<br>(c) the ACAT believes on reasonable grounds that, because of the mental illness, the person—<br>(i) is doing, or is likely to do, serious harm to themselves or someone else; or<br>(ii) is suffering, or is likely to suffer, serious mental or physical deterioration; and<br>(d) in relation to a person mentioned in paragraph (b) (ii)—the ACAT is satisfied that the harm or deterioration, or likely harm or deterioration, mentioned in paragraph (c) is of | <ul style="list-style-type: none"> <li>Capacity defined in section 7 (functional approach). Definition reflects supported decision-making approach ('if the person can, with assistance if needed')</li> <li>Section 8 sets out principles that apply when assessing decision-making capacity. <ul style="list-style-type: none"> <li>Capacity is decision-specific: s 8(1)(a).</li> <li>Rebuttable presumption in favour of capacity: s 8(1)(b), also reflected in s 6(i).</li> <li>Person who lacks capacity must always be supported to make decisions to the best of their ability: s 8(1)(c).</li> <li>A person is not to be treated as lacking capacity unless all practical steps to assist the person to make decisions have been taken: s 8(1)(d).</li> </ul> </li> </ul> |

| Jurisdiction                                                   | Criteria for involuntary treatment for mental illness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Approach to capacity                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                | <p>such a serious nature that it outweighs the person's right to refuse to consent; and</p> <p>(e) the ACAT is satisfied that psychiatric treatment, care or support is likely to—</p> <p>(i) reduce the harm or deterioration, or the likelihood of the harm or deterioration, mentioned in paragraph (c); or</p> <p>(ii) result in an improvement in the person's psychiatric condition; and</p> <p>(f) if an application has been made for a forensic mental health order—the ACAT is satisfied that a psychiatric treatment order should be made instead; and</p> <p>(g) the ACAT is satisfied that the treatment, care or support to be provided under the psychiatric treatment order cannot be adequately provided in another way that would involve less restriction of the freedom of choice and movement of the person.</p>                                                                                                                                                                                                                                                                                 | <ul style="list-style-type: none"> <li>○ Person is not to be treated as lacking capacity only because 'the person makes an unwise decision': s8(1)(e)</li> <li>○ Person is not to be treated as having capacity only because the person complies with treatment: s 8(1)(f)</li> <li>○ Person who has fluctuating capacity must, if reasonably practicable, be assessed at a time when they have decision-making capacity: s 8(1)(g).</li> </ul>                   |
| <p><b>NSW:</b><br/><i>Mental Health Act 2007</i><br/>(NSW)</p> | <p>Section 12(1):<br/>A patient or other person must not be involuntarily admitted to, or detained in or continue to be detained in, a mental health facility unless an authorised medical officer is of the opinion that –</p> <p>(a) the person is a mentally ill person or a mentally disordered person, and</p> <p>(b) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.</p> <p>Section 14:<br/>(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary—</p> <p>(a) for the person's own protection from serious harm, or</p> <p>(b) for the protection of others from serious harm.</p> <p>(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.</p> | <ul style="list-style-type: none"> <li>• Section 68(h1) (Principles for care and treatment) states that:<br/>'every effort that is reasonably practicable should be made to obtain the consent of people with mental illness or mental disorder when developing treatment plans and recovery plans for their care, to monitor their capacity to consent and to support people who lack that capacity to understand treatment plans and recovery plans'</li> </ul> |
| <p><b>Qld:</b><br/><i>Mental Health Act 2016</i> (Qld)</p>     | <p>Section 12:<br/>(1) The treatment criteria for a person are all of the following:</p> <p>(a) the person has a mental illness</p> <p>(b) the person does not have capacity to consent to be treated for the illness</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <ul style="list-style-type: none"> <li>• Section 5(b) (matters to be considered in making decisions) includes a presumption in favour of capacity.</li> <li>• Capacity defined in s 14(1) (functional approach).</li> </ul>                                                                                                                                                                                                                                       |

| Jurisdiction                                               | Criteria for involuntary treatment for mental illness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Approach to capacity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                            | <p>(c) because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in –</p> <p>(i) imminent serious harm to the person or others; or</p> <p>(ii) the person suffering serious mental or physical deterioration</p> <p>(2) For subsection (1)(b), the person's own consent only is relevant</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <ul style="list-style-type: none"> <li>Section 14(2) provides that a person 'may have capacity to consent to be treated even though the person decides not to receive treatment'</li> <li>Section 14(3) provides that 'a person may be supported by another person in understanding the matters mentioned in subsection (1)(a) and making a decision about the treatment'</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>TAS:</b><br><i>Mental Health Act 2013 (Tas)</i>         | <p>Section 40: The treatment criteria in relation to a person are –</p> <p>(a) the person has a mental illness; and</p> <p>(b) without treatment, the mental illness will, or is likely to, seriously harm –</p> <p>(i) the person's health or safety; or</p> <p>(ii) the safety of other persons; and</p> <p>(c) the treatment will be appropriate and effective in terms of the outcomes referred to in section 6(1); and</p> <p>(d) the treatment cannot be adequately given except under a treatment order; and</p> <p>(a) the person does not have decision-making capacity.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <ul style="list-style-type: none"> <li>Section 7 includes a presumption in favour of capacity and definition of capacity (functional approach).</li> <li>Section 7(1)(a) provides that a person has capacity unless they are 'unable to make the decision because of an impairment or, or disturbance in, the functioning of the mind or brain' and cannot pass the functional test in s7(b).</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Vic:</b><br><i>Mental Health and Wellbeing Act 2022</i> | <p>Section 143: [compulsory treatment criteria]</p> <p>(a) the person has mental illness; and</p> <p>(b) because the person has mental illness, the person needs immediate treatment to prevent—</p> <p>i. serious deterioration in the person's mental or physical health; or</p> <p>ii. serious harm to the person or to another person; and</p> <p>(c) if the person is made subject to a temporary treatment order or treatment order, the immediate treatment will be provided to the person; and</p> <p>d) (there are no less restrictive means reasonably available to enable the person to receive the immediate treatment.</p> <p>Section 89: [An authorized psychiatrist can make a treatment decision if...]</p> <ul style="list-style-type: none"> <li>the patient does not have capacity to give informed consent to treatment proposed, or has capacity but does not give informed consent: s 89(1)(a); and</li> <li>the treatment is not ECT or neurosurgery: s 89(1)(b); and</li> <li>the treatment is clinically appropriate: s 89(3)(a); and</li> <li>there is no less restrictive way for the patient to be treated [taking into account factors in s 89(4)]: s 89(3)(b)</li> </ul> | <ul style="list-style-type: none"> <li>Section 85 includes a presumption in favour of capacity.</li> <li>Section 87(1) provides definition of capacity (functional approach).</li> <li>Section 87(2) sets out factors that must be considered in deciding capacity: <ul style="list-style-type: none"> <li>capacity is decision-specific: s 87(2)(a)</li> <li>capacity may fluctuate: s 87(2)(b)</li> <li>lack of capacity should not be assumed based on age, appearance, disability, condition or behaviour: s87(2)(c), or because decision could be considered unwise: s87(2)(d)</li> <li>whether the person can provide informed consent with appropriate supports: s87(2)(e) [supported decision-making]</li> </ul> </li> <li>Section 87(3) requires that: <ul style="list-style-type: none"> <li>assessment be done in a time/place where capacity can be determined most accurately: s 87(3)(a)</li> <li>the person is provided with appropriate supports to enable them to give informed consent: s 87(3)(b)</li> </ul> </li> </ul> |

| Jurisdiction                                                                          | Criteria for involuntary treatment for mental illness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Approach to capacity                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>WA:</b><br><i>Mental Health Act 2014 (WA)</i>                                      | <p>Section 25(1): [criteria for inpatient treatment]</p> <p>(a) that the person has a mental illness for which the person is in need of treatment; and</p> <p>(b) that, because of the mental illness, there is –</p> <p>(i) a significant risk to the health or safety of the person or to the safety of another person; or</p> <p>(ii) a significant risk of serious harm to the person or to another person;</p> <p>(c) that the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;</p> <p>(d) that treatment in the community cannot reasonably be provided to the person</p> <p>(e) that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order.</p> <p>[Criteria for community treatment order set out in s 25(2)]</p> | <ul style="list-style-type: none"> <li>• Section 13(1) includes presumption in favour of capacity.</li> <li>• Section 15(1) includes a general definition of capacity (functional approach).</li> <li>• Section 18 applies the criteria in section 15 to 'treatment decisions' specifically.</li> </ul>                                                                                                                                            |
| <b>SA:</b> <i>Mental Health Act 2009 (SA)</i>                                         | <p>Section 21(1): [Criteria for level 1 inpatient treatment order]</p> <p>(a) the person has a mental illness; and</p> <p>(b) because of the mental illness, the person requires treatment for the person's own protection from harm (whether physical or mental, and including harm involved in the continuation of deterioration of the person's condition) or for the protection of others from harm; and</p> <p>(ba) the person has impaired decision-making capacity relating to appropriate treatment of the person's mental illness; and</p> <p>(c) there is no less restrictive means than an inpatient treatment order of ensuring appropriate treatment of the person's illness.</p> <p>See also section 25(2) setting out criteria for level 2 (longer) inpatient treatment orders.</p> <p>See s 10 setting out criteria for level 1 community treatment orders.</p>                                                                                          | <ul style="list-style-type: none"> <li>• Section 5A includes presumption in favour of capacity and definition of 'impaired decision-making capacity' (functional approach, also taking into account advanced care directives).</li> <li>• Section 5A(3) recognises capacity as fluid [at (c)] and stipulates that capacity is not impaired merely because decision results or may result in an adverse outcome for the person [at (d)].</li> </ul> |
| <b>NT:</b><br>Mental Health and Related Services Act 1998<br>(currently under review) | <p>Section 14:</p> <p>(a) the person has a mental illness; and</p> <p>(b) as a result of the mental illness:</p> <p>i. the person requires treatment that is available at an approved treatment facility; and</p> <p>ii. without the treatment, the person is likely to:</p> <p>A. cause serious harm to himself or herself or to someone else; or</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <ul style="list-style-type: none"> <li>• No presumption for/against capacity.</li> <li>• No definition of capacity or guidance on assessing capacity.</li> <li>• Informed consent is defined in s 7. The definition includes the requirement that 'the person is <i>capable of understanding</i> the effects of giving consent': s 7(2)(b).</li> </ul>                                                                                             |

| Jurisdiction | Criteria for involuntary treatment for mental illness                                                                                                                                                                                                                                                                                                           | Approach to capacity |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
|              | <p>B. suffer serious mental or physical deterioration; and</p> <p>iii. the person is not capable of giving informed consent to treatment or has unreasonably refused to consent</p> <p>(c) there is no less restrictive means of ensuring that the person receives the treatment</p> <p>[See also s 16 setting out criteria for community treatment orders]</p> |                      |

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## **REFORMING THE FITNESS TO BE TRIED PROCEDURE IN IRELAND TO COMPLY WITH THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES**

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### **I. INTRODUCTION**

A criminal trial involves the balancing of three competing rights: the public interest in seeing offenders prosecuted and punished, the right of the victim to have their rights vindicated,<sup>1</sup> and the right of the accused to receive a fair trial. Where there is a conflict, the accused's right to a fair trial will be considered superior to the public interest and the rights of the victim.<sup>2</sup> The procedures which declare an accused unfit to plead/be tried/stand trial result from this balancing exercise. To stand trial or enter a plea, a person must have an adequate ability to communicate and a sufficient cognitive faculty to be able to understand the proceedings.<sup>3</sup> Where either is absent, the accused is protected from the risk of an unfair trial, and possible criminal sanctions, until such time as they recover to the extent necessary to participate meaningfully in their own defence.

The procedure by which a person is declared unfit to be tried, and its potential consequences, are not without its drawbacks. They can deprive a person of the right to be equal under the law<sup>4</sup> and their right to autonomy by removing their ability to make their own decisions.<sup>5</sup> They can prevent them from being held responsible for their actions or from clearing their name,<sup>6</sup> based on the existence of a disability. They can also result in a loss of liberty,<sup>7</sup> despite the lack of a criminal conviction or full trial, on an indefinite basis. As a result of these defects, two commentators have described the process as a "cruelly ironic way" to try to ensure that persons with disabilities are treated fairly.<sup>8</sup>

This article considers reform of the fitness to be tried procedures currently used in Ireland, in light of the ratification of the Convention on the Rights of Persons with

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<sup>1</sup> *Attorney General's Reference (No. 3 of 1999)* [2001] 2 AC 91.

<sup>2</sup> *People (DPP) v Harrison* [2016] IECA 212 [48] (Edwards J).

<sup>3</sup> Ralph Slovenko, 'The Developing Law on Competency to Stand Trial' (1977) 5 J Psychiatry & L 165, 166 <https://dx.doi.org/10.1177/009318537700500202>.

<sup>4</sup> The right to equality before the law is protected by the Constitution of Ireland; 1937 Constitution, Article 40.1.

<sup>5</sup> The right to autonomy is a derived personal right under the Constitution of Ireland; 1937 Constitution, Article 40.3.1°. See *Creighton v Ireland* [2010] IESC 50 [4] (Fennelly J).

<sup>6</sup> The right to a good name is protected by the Constitution of Ireland; 1937 Constitution, Article 40.3.2°.

<sup>7</sup> The right to personal liberty is protected by the Constitution of Ireland; 1937 Constitution, Article 40.4.1°.

<sup>8</sup> Robert A Burt & Norval Morris, 'A Proposal for the Abolition of the Incompetency Plea' (1972) 40 U Chi L Rev 66, 75 <https://doi-org.ucc.idm.oclc.org/10.2307/1599068>.



Disabilities in 2018.<sup>9</sup> The CRPD places an emphasis on protecting a person's legal capacity and removing any legal processes which implement substitute decision-making. It is challenging to accomplish this objective whilst still protecting the accused's right to a fair trial, particularly as fundamental protections regarding a fair trial under the Irish Constitution and the European Convention on Human Rights (ECHR)<sup>10</sup> must be given priority in domestic law.

This article consists of four main sections. Section II describes the current fitness to be tried procedure in Irish law. Section III then assesses whether the current law is compliant with the CRPD and considers how the Committee on the Rights of Persons with Disabilities (Committee) views on supported decision-making impact the right to a fair trial. It is determined that the CRPD does not require the complete abolition of unfitness to be tried declarations, but does require greater safeguards, such as an assessment of the supports a person with a disability requires, an increased focus on the accused's right to access justice, and a reconsideration of provisions that permit these defendants to be detained without a trial indefinitely. Finally, using the insights gained in section III, section IV considers reform in this area.

## II. FITNESS TO BE TRIED IN IRISH LAW

### *A. The Statutory Test and Procedure under Irish Law*

In Ireland, a declaration that an accused is unfit to be tried is made when, by reason of a mental disorder,<sup>11</sup> they are unable to:

understand the nature or course of the proceedings so as to:

- (a) plead to the charge,
- (b) instruct a legal representative,
- (c) in the case of an indictable offence which may be tried summarily, elect for a trial by jury,
- (d) make a proper defence,
- (e) in the case of a trial by jury, challenge a juror to whom he or she might wish to object, or
- (f) understand the evidence.<sup>12</sup>

The issue can arise at any point of criminal proceedings and be raised by either party or the court itself.<sup>13</sup> The determination is made by the court of trial,<sup>14</sup> by the judge sitting alone.<sup>15</sup> The judge may request the evidence of a consultant psychiatrist as to

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<sup>9</sup> Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3 (CRPD).

<sup>10</sup> Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (adopted 4 November 1950, entered into force 3 September 1953) (ECHR).

<sup>11</sup> The statute only covers cases where the unfitness is caused by a mental disorder. If the accused suffers from another form of disability, the common law test continues to apply; Simon Mills, 'Criminal Law (Insanity) Bill 2002: Putting the sanity back into insanity' (2003) 8 Bar Rev 101, 102. A mental disorder is defined as including "mental illness, mental disability, dementia or any disease of the mind but does not include intoxication"; Criminal Law (Insanity) Act 2006, s 1. Mental disability includes intellectual disabilities.

<sup>12</sup> 2006 Act (n 11) s 4(2).

<sup>13</sup> *ibid*, s 4(1).

<sup>14</sup> *ibid*, s 4(3)(a), s 4(4)(a).

<sup>15</sup> *ibid*, s 4(4)(b), s 4(5)(b).



the condition of the accused.<sup>16</sup> A right of appeal exists to the Circuit Court, where the decision was made by the District Court, or otherwise the Court of Appeal against a determination of unfitness.<sup>17</sup> The legislation does not directly provide for a right of appeal against a determination of fitness, however any resulting conviction can be quashed if the accused is subsequently found unfit to be tried.<sup>18</sup>

Upon a determination that an accused is unfit to be tried, criminal proceedings are adjourned and the court may issue a committal order to a designated centre if it is satisfied that, on considering medical evidence, the accused has a mental disorder within the meaning of the Mental Health Act 2001<sup>19</sup> and is in need of in-patient care or treatment.<sup>20</sup> Issuing a committal order is a two-step process: the accused must first be detained for a period of fourteen days for the purposes of examination by an approved medical officer,<sup>21</sup> and may then be detained for an indefinite period after a second hearing which considers the opinion of the approved medical officer following the examination. Alternatively, the court is also permitted to issue an order for out-patient care or treatment, in the event it determines that this is more appropriate.<sup>22</sup>

The court also has the power to defer consideration and determination of the issue until before the opening of the defence's case, allowing the trial judge to grant a directed acquittal if appropriate, rendering the issue moot.<sup>23</sup> Additionally, after a defendant has been found unfit to be tried, an application can be made to the court for a hearing to determine whether reasonable doubt exists as to the defendant's guilt.<sup>24</sup> The purpose of this section was to ensure that a person was not being detained unnecessarily under the criminal law.<sup>25</sup>

The legislation states that the accused will be "discharged" if the court is satisfied that reasonable doubt exists following a "trial of the facts".<sup>26</sup> Reporting on evidence adduced during a "trial of the facts" is an offence unless the accused is discharged because a reasonable doubt exists, a trial has concluded, or a decision has otherwise

<sup>16</sup> *ibid*, s 4(3)(aa), s 4(5)(bb).

<sup>17</sup> *ibid*, s 7(1), s 7(3).

<sup>18</sup> *People (DPP) v Redmond* (COA, 22 July 2019) (Birmingham P).

<sup>19</sup> Mental disorder is defined as meaning "mental illness, severe dementia or significant intellectual disability where (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent"; Mental Health Act 2001, s 3(1).

<sup>20</sup> 2006 Act (n 11) s 4(3)(b)(i), s 4(5)(c)(i).

<sup>21</sup> *ibid*, s 4(6)(a)(i)(I).

<sup>22</sup> *ibid*, s 4(3)(b)(ii), s 4(5)(c)(ii).

<sup>23</sup> *ibid*, s 4(7).

<sup>24</sup> *ibid*, s 4(8).

<sup>25</sup> Department of Justice, Equality and Law Reform, *Criminal Law (Insanity) Bill 2002 – Explanatory and Financial Memorandum* (Department of Justice, Equality and Law Reform 2002) 3 <https://data.oireachtas.ie/ie/oireachtas/bill/2002/44/eng/memo/b4402s-memo.pdf>.

<sup>26</sup> *ibid*.

been made not to proceed with the prosecution.<sup>27</sup> This restriction is to protect the accused's right to a good name and is a recognition of the fact that they were unable to make a proper defence at this hearing.<sup>28</sup>

### *B. Review of Detention*

In Ireland, the only designated centre is the Central Mental Hospital in Portrane, County Dublin. An independent review board, known as the Mental Health (Criminal Law) Review Board (Review Board), was established by the 2006 Act to review the detention of patients committed as a result of unfitness to be tried declarations.<sup>29</sup> A patient's detention is reviewed at least every six months.<sup>30</sup> After considering evidence relating to the patient's mental condition, the Review Board can make any order regarding committal and treatment that it thinks proper.<sup>31</sup> Reviews can also take place outside of this cycle, either at the request of the patient,<sup>32</sup> on the Review Board's own initiative,<sup>33</sup> or if the clinical director of the Central Mental Hospital forms the opinion that the patient is no longer in need of inpatient treatment.<sup>34</sup> If either the clinical director or the Review Board forms the opinion that the patient is no longer unfit to be tried, they must notify the court that detained the patient, which will order the patient to be brought before it.<sup>35</sup>

## III. ASSESSING COMPLIANCE OF FITNESS TO BE TRIED PROCEDURE WITH THE CRPD

### *A. Overview of the CRPD*

The CRPD was ratified by Ireland in March 2018.<sup>36</sup> It emphasises that persons with disabilities have the right to an equal enjoyment of all human rights. These rights include the right to equal recognition and legal capacity (Article 12), the right to an equal access to justice (Article 13), the right to liberty (Article 14), the right not to be tortured (Article 15), and the right to freedom from abuse (Article 16). Where a person requires support or "reasonable accommodation" in order to enjoy a human right on an equal basis with others, this should be provided.<sup>37</sup> However, Article 2 clarifies that the CRPD requires only "reasonable accommodation" and it does not require any adjustments or modifications which impose a "disproportionate or undue burden" on

<sup>27</sup> 2006 Act (n 11) s 4(9).

<sup>28</sup> Liz Campbell, Shane Kilcommins, Catherine O'Sullivan & Alan Cusack, *Criminal Law in Ireland: Cases and Commentary* (2nd edn, Clarus Press 2021) [26-56].

<sup>29</sup> 2006 Act (n 11) s 11 as amended by Criminal Law (Insanity) Act 2010, s 6.

<sup>30</sup> 2006 Act (n 11) s 13(1) as amended by Criminal Justice Act 2006, s 197(1).

<sup>31</sup> 2006 Act (n 11) s 13(4) as amended by 2010 Act (n 29) s 7.

<sup>32</sup> 2006 Act (n 11) s 13(7) as amended by Defence (Amendment) Act 2007, s 11.

<sup>33</sup> 2006 Act (n 11) s 13(9) as amended by CJA 2006 (n 30) s 197(1).

<sup>34</sup> 2006 Act (n 11) s 13(3) as amended by CJA 2006 (n 30) s 197(1).

<sup>35</sup> 2006 Act (n 11) s 13(2)(a) as amended by CJA 2006 (n 30) s 197(1); 2006 Act (n 11) s 13(2)(a) as amended by 2007 Act (n 32) s 11.

<sup>36</sup> United Nations Treaty Collection, 'Ratifications and Signatures of the C.R.P.D.' <[https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsq\\_no=IV-15&chapter=4&clang=en#EndDec](https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsq_no=IV-15&chapter=4&clang=en#EndDec)> accessed 6 July 2025.

<sup>37</sup> CRPD (n 9) Article 5.4.



the State.<sup>38</sup> Article 1 states that persons with disabilities include persons with mental or intellectual impairments.

At the time of ratification, Ireland issued declarations regarding Articles 12 and 14, stating that Article 12 was understood as permitting substitute decision-making where necessary and subject to safeguards and that Article 14 was understood as permitting compulsory care as a last resort.<sup>39</sup> Ireland also stated that if it should be determined that Article 12 prohibits substitute decision-making, the State was reserving the right to permit such arrangements subject to safeguards when appropriate.<sup>40</sup> It should also be noted that as Ireland is a dualist country, the CRPD does not automatically form part of domestic law despite ratification. This means that where there is a clash between the CRPD and the Irish Constitution or the ECHR, the latter must take priority. The Irish Constitution is the highest source of national law in Ireland, and any legislation must be compliant with its provisions.<sup>41</sup> The ECHR was incorporated into national law in 2003, and courts must interpret legislation in a manner which is compatible with the ECHR<sup>42</sup> or make a “declaration of incompatibility”.<sup>43</sup> Every organ of the state must perform its functions in a manner compatible with the ECHR.<sup>44</sup>

### *B. Legal Capacity and Supported Decision-Making*

Article 12 of the CRPD requires that the legal capacity of people with disabilities is respected on an equal basis with others. Legal capacity includes the right to have one’s actions and choices recognised by the law, even if one’s decision-making skills are impaired.<sup>45</sup> The Committee, which was established by Article 34 and is primarily responsible for monitoring compliance with the treaty, considers the functional approach to be discriminatory as it assesses mental capacity to determine if legal capacity should be respected resulting in the lowering of a person’s status before the law.<sup>46</sup>

The fitness to be tried process assesses the accused’s mental capacity to ensure that they can understand matters relevant to the trial and assist in their own defence. However, when the accused is unable to satisfy this test, they are declared ‘unfit’. As this process denies the accused their legal capacity, it is potentially not compliant with Article 12. The solution, according to the Committee, is to provide support for persons who may have impaired decision-making skills to help them stand trial, rather than deny them their legal capacity.<sup>47</sup>

<sup>38</sup> *ibid*, Article 2.

<sup>39</sup> UNTC (n 36).

<sup>40</sup> *ibid*.

<sup>41</sup> 1937 Constitution, Article 15.4.

<sup>42</sup> European Convention on Human Rights Act 2003, s 2(1).

<sup>43</sup> *ibid*, s 5.

<sup>44</sup> *ibid*, s 3(1).

<sup>45</sup> UN Committee on the Rights of Persons with Disabilities, ‘General Comment No 1 – Article 12: Equal Recognition Before the Law’ (2014) UN Doc CRPD/C/GC/1 [14] <https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no-1-article-12-equal-recognition-1>.

<sup>46</sup> *ibid* [15].

<sup>47</sup> *ibid*.

A finding that an accused is unfit to stand trial is a form of substitute decision-making. The judge is deciding that it is in the accused's best interests that they do not stand trial, regardless of what the accused might want.<sup>48</sup> This process is paternalistic; it is designed to protect defendants that the court feels are vulnerable and to ensure that the trial is fair.<sup>49</sup> It is feared that there is a greater risk of a wrongful conviction if the accused cannot participate effectively in the trial, particularly if their counsel is unable to obtain information essential to their defence.<sup>50</sup> The key difference between the paternalistic unfit to be tried process and the CRPD respect for legal capacity regime is that the former results in a decision which is in the objective best interests of the person, and the other results in a decision which aims to be the will and preference of the person and fully protects their rights. The latter decision may appear unwise to some observers, but it is regarded as preferable because it does not interfere with the legal capacity of the person, which when deprived hinders full and effective participation in society. Supported decision-making also ensures that the voices of persons with disabilities are heard.

There are several decisions that an accused might need to make during a trial which are relevant to being found fit to stand trial: the accused needs to elect how to plead, whether to challenge a juror, what defence they wish to raise, and whether (in appropriate cases) they elect to have a summary trial or a trial by jury. Support may also be required beyond just decision-making in order to help the accused follow and understand the proceedings. Supported decision-making is defined by the Committee as one way in which a person receives support in the exercise of their legal capacity and relates specifically to when a particular decision needs to be made. This approach is endorsed by Article 12.3 of the CRPD. Thus, rather than declaring a person unable to make their own decisions and appointing a third party to make these decisions, the person is given assistance to express their will and preferences and protect their rights. The type and magnitude of the support will differ according to the person's needs. The Committee advised that:

persons with disabilities may choose one or more trusted support persons to assist them in exercising their legal capacity for certain types of decisions, or may call on other forms of support, such as peer support, advocacy (including self-advocacy support), or assistance with communication. Support to persons with disabilities in the exercise of their legal capacity might include measures relating to universal design and accessibility — for example, requiring private and public actors, such as banks and financial institutions, to provide information in an understandable format or to provide professional sign language interpretation — in order to enable persons with disabilities to perform the legal acts required to open a bank account, conclude contracts or conduct other social transactions. Support can also constitute the development and recognition of diverse, non-conventional methods of communication, especially for those who use non-verbal forms of communication to express their will and preferences.<sup>51</sup>

<sup>48</sup> *ibid.*

<sup>49</sup> *O'C v Judges of Dublin Metropolitan District* [1994] 3 IR 246, 251-252 (Finlay CJ).

<sup>50</sup> Stuart E Eizenstat, 'Mental Competency to Stand Trial' (1969) 4 Harv CR-CL L Rev 379, 379 <https://heinonline.org/HOL/P?h=hein.journals/hcrcl4&i=385>.

<sup>51</sup> General Comment No 1 (n 45) [17].

A person with a disability is not obliged to accept or ask for help. They are entitled to insist that decisions made without support are respected.<sup>52</sup> This support must replace any substitute decision-making regime where a person is deprived of legal capacity, even if only for a single decision.<sup>53</sup>

### *C. Issues with Identifying a Person's Will and Preferences*

Although supported decision-making respects a person's legal capacity, it can be challenging to implement when the patient is unable to express their will and preferences. In this instance, Article 12.4, following guidance from the Committee, directs that a facilitated decision-making process should take place which must be based on the "best interpretation of will and preferences" that can be formulated rather than what is perceived to be in their best interests.<sup>54</sup> This approach prioritises the views of persons with disabilities. Unfortunately, the Committee has not provided much detail on how this could be achieved. The Committee has recommended that States Parties provide "various forms of advance planning mechanisms to accommodate various preferences" to aid a facilitated decision-maker.<sup>55</sup> It views the ability to plan ahead as an important form of support for persons with disabilities.<sup>56</sup>

By using advance planning mechanisms, a person can state their will and preferences for a time in the future when they might be unable to communicate them.<sup>57</sup> The Committee directs that an advance directive should include the decision of the person regarding "the point at which ... [it] ... enters into force ... and ceases to have effect".<sup>58</sup>

The Committee further emphasised that an assessment that a person lacks mental capacity cannot be used to invoke the provisions of an advance directive, unless it is that person's desire.<sup>59</sup> This is to prevent an advance directive being used against a person who is perceived as behaving unwisely in the future.

It is not clear how these advance planning mechanisms would be relevant to criminal justice matters. It would not be possible for a person to advance plan what their will and preferences would be in relation to their defence for a crime that may not have occurred yet. Further, this approach implies that the only relevant consideration in ensuring a fair trial is that the accused's wishes are known. Fair trial protection under the Irish Constitution<sup>60</sup> and the ECHR<sup>61</sup> is wider than this, and because of the status of these legal sources in domestic law, these rights have to take priority.

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<sup>52</sup> *ibid* [19].

<sup>53</sup> *ibid* [27].

<sup>54</sup> *ibid* [21].

<sup>55</sup> *ibid* [17].

<sup>56</sup> *ibid*.

<sup>57</sup> *ibid*.

<sup>58</sup> *ibid*.

<sup>59</sup> *ibid*.

<sup>60</sup> 1937 Constitution, Article 38.1; See *Blanchfield v Hartnett* [2002] 3 IR 207, 221 (Fennelly J).

<sup>61</sup> Defendants have the following minimum rights under Article 6.3 of the ECHR:

- (a) to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;
- (b) to have adequate time and the facilities for the preparation of his defence;

Whilst there is no exhaustive list of the components which are required in order to constitute a fair trial in the Constitution itself,<sup>62</sup> it is particularly important that an accused has an adequate opportunity to make a full answer and defence. This is based on the principle of “equality of arms” which provides that the trial should not take place in circumstances where the accused is placed at a substantial disadvantage against their opponent (the prosecution).<sup>63</sup> The accused is not able to waive this right to a fair trial as judges are not permitted to allow unconstitutional trials to proceed.<sup>64</sup> As a result, a court is obliged to find a defendant unfit to stand trial if the statutory test is satisfied, even if the defendant objects and wishes to proceed with the trial.<sup>65</sup> Similarly, Article 6 of the ECHR requires that the accused is able to participate effectively in their trial.<sup>66</sup> This requires that:

the accused has a broad understanding of the nature of the trial process and of what is at stake for him or her, including the significance of any penalty which may be imposed. It means that he or she, if necessary, with the assistance of, for example, an interpreter, lawyer, social worker or friend, should be able to understand the general thrust of what is said in court. The defendant should be able to follow what is said by the prosecution witnesses and, if represented, to explain to his own lawyers his version of events, point out any statements with which he disagrees and make them aware of any facts which should be put forward in his defence.<sup>67</sup>

Thus, even if a best interpretation of a person’s will and preferences could be formulated, it seems that this would not be enough to ensure a fair trial under the Constitution or ECHR. Both these instruments appear to require active participation from an accused and must take precedence over the CRPD.

#### *D. The Committee’s Views on Fitness to be Tried Procedures*

The Committee has confirmed that when a person is deemed “incapable of discernment” and procedural and age-appropriate accommodations are not provided to allow them to participate in judicial proceedings, this will not comply with Article

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(c) to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;

(d) to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;

(e) to have the free assistance of an interpreter if he cannot understand or speak the language used in court.

<sup>62</sup> Some of the ingredients are discussed by Gannon J in *State (Healy) v Donoghue* [1975] IR 325, 335: the [right] to be adequately informed of the nature and substance of the accusation, to have the matter tried in his presence by an impartial and independent court or arbitrator, to hear and test by examination the evidence offered by or on behalf of his accuser, to be allowed to give or call evidence in his defence, and to be heard in argument or submission before judgment be given. By mentioning these I am not to be taken as giving a complete summary, or of excluding other rights such as the right to reasonable expedition and the right to have an opportunity for preparation of the defence.

<sup>63</sup> Tom O’Malley, *The Criminal Process* (Round Hall 2009) [4-13] *et seq.*

<sup>64</sup> *State (Byrne) v Frawley* [1978] IR 326, 344-345 (Henchy J).

<sup>65</sup> *O’C* (n 49) 252 (Finlay CJ).

<sup>66</sup> *T & V v United Kingdom* (2000) 30 EHRR 12 [85].

<sup>67</sup> *ibid* [29].

13.<sup>68</sup> In particular, the Committee has highlighted that legislation that views persons with disabilities as unfit to be tried violates Article 13 as it restricts their access to achieving justice in their case.<sup>69</sup>

Regarding compatibility with Article 12, the Committee did not explicitly discuss unfit to be tried determinations in its General Comment on Article 12, but the issue arose for its consideration in a complaint submitted under the Optional Protocol. In *Noble v Australia*,<sup>70</sup> the applicant had been charged with several sexual offences against children. He was found unfit to stand trial, the charges were quashed, and he was detained in a prison. He spent over a decade in prison before being discharged subject to several strict conditions. The complaint alleged that the applicant's detention and the conditions imposed upon his release violated Article 14.<sup>71</sup> It was also argued that he was deprived of the opportunity to plead not guilty and to "test the evidence" and was thus still presumed guilty, violating Article 12.

Australia argued that although the fitness to plead legislation resulted in differential treatment, it was on legitimate grounds and subject to safeguards.<sup>72</sup> The Committee acknowledged that not all differential treatment was discriminatory and prohibited by Article 5 of the CRPD, and that such treatment could be legitimate if it was reasonable.<sup>73</sup> The Committee noted that the State had not provided the applicant with any support to enter a plea, and had not analysed whether such measures could have been adopted, and this was a violation of Articles 12 and 13.<sup>74</sup>

It is important to note that the Committee did not declare that an unfitness to plead declaration was an automatic violation of the CRPD but rather based its finding on the failure of Australia to adequately consider what support could be provided. The Committee also found a violation of Article 14. It noted that the charges had been dismissed and Mr Noble had been detained in a prison despite not having been convicted of any offence. The State conceded that the decision to detain in a prison was because of the "lack of available alternatives and support services", an admission that the Committee felt supported the view that the applicant's disability was the core cause of his detention.<sup>75</sup> It also noted that any conditions that are imposed upon release from detention also fell foul of Article 14.

Finally, the Committee found that the indefinite character of the detention violated Article 15, which protects persons with disabilities from "torture or cruel, inhuman or degrading treatment or punishment".<sup>76</sup> It noted the "irreparable psychological effects" that indefinite detention can have on a detainee and considered that it was "inhuman

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<sup>68</sup> Committee on the Rights of Persons with Disabilities, 'Concluding observations on the initial report of Switzerland' (2022) UN Doc CRPD/C/CHE/CO/1 [27]-[28].

<sup>69</sup> Committee on the Rights of Persons with Disabilities, 'Concluding observations on the initial report of Australia' (2019) UN Doc CRPD/C/AUS/CO/2-3 [25]-[26].

<sup>70</sup> *Noble v Australia* (CRPD/C/16/D/7/2012) (Decision of 2 September 2016).

<sup>71</sup> *ibid* [7.8].

<sup>72</sup> *ibid* [8.2].

<sup>73</sup> *ibid* [8.3].

<sup>74</sup> *ibid* [8.4].

<sup>75</sup> *ibid* [8.7].

<sup>76</sup> CRPD (n 9) Article 15.1.



and degrading treatment”.<sup>77</sup> Article 15 was also violated because the applicant was subjected to violence and abuse in prison that he was unable to protect himself from as a result of his disability. The State was under an obligation to prevent or protect the applicant from this abuse.<sup>78</sup>

It is not entirely clear from the *Noble* decision how broadly the decision is to be interpreted. There was an acknowledgment that some degree of differential treatment may be reasonable, but the Committee was silent on what that might be. Presumably any measures which are necessary to achieve equality will be permissible, a position endorsed by Article 5.4 of the CRPD.<sup>79</sup> However, in its Guidelines on Article 14, the Committee was more forceful in its views that unfit to be tried declarations were not CRPD compliant:

[t]he Committee has established that declarations of unfitness to stand trial ... in criminal justice systems and the detention of persons based on those declarations is contrary to article 14 of the Convention since it deprives the person of his or her right to due process and safeguards that are applicable to every defendant. The Committee has also called for States parties to remove those declarations from the criminal justice system. The Committee has recommended that all persons with disabilities who have been accused of crimes and... detained in jails and institutions, without trial, are allowed to defend themselves against criminal charges, and are provided with required support and accommodation to facilitate their effective participation, as well as procedural accommodations to ensure fair trial and due process.<sup>80</sup>

Gooding *et al*/interpret the Committee’s comments in the Guidelines on Article 14 as obliging States Parties to remove all declarations of unfitness from national law.<sup>81</sup> However, it could perhaps be argued that this is ignoring the context of the comments, which concerned persons deprived of their liberty without the chance to defend themselves at a trial. If a person is declared unfit to stand trial and is not detained, this does not violate Article 14.

Gooding *et al*/also cite the Committee’s Concluding Observations for Ecuador and South Korea<sup>82</sup> as evidence that this direction is not contingent on involuntary detention. However, the Committee’s concerns were again expressed in a discussion of Article 14 and appear to be primarily concerned with the misuse of using the

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<sup>77</sup> *Noble* (n 70) [8.9].

<sup>78</sup> *ibid*.

<sup>79</sup> CRPD (n 9) Article 5.4.

<sup>80</sup> Committee on the Rights of Persons with Disabilities ‘Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities’ (2015) [16] <https://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc#:~:text=Article%2014%20of%20the%20Convention%20is%2C%20in%20essence%2C%20a%20non,on%20disability%20in%20its%20exercise.>

<sup>81</sup> Piers Gooding, Bernadette McSherry, Anna Arstein-Kerslake & Louis Andrews, ‘Unfitness to Stand Trial and the Indefinite Detention of Persons with Cognitive Disabilities in Australia: Human Rights Challenges and Proposals for Change’ (2017) 40 *Melb Univ Law Rev* 816, 843 [https://www.proquest.com/scholarly-journals/unfitness-stand-trial-indefinite-detention/docview/1899315486/se-2.](https://www.proquest.com/scholarly-journals/unfitness-stand-trial-indefinite-detention/docview/1899315486/se-2)

<sup>82</sup> Committee on the Rights of Persons with Disabilities, ‘Concluding observations on the initial report of Ecuador’ (2014) UN Doc CRPD/C/ECU/CO/1 [28]-[29]; Committee on the Rights of Persons with Disabilities, ‘Concluding observations on the initial report of Republic of Korea’ (2014) UN Doc CRPD/C/KOR/CO/1 [27]-[28].

unfitness to stand trial process to detain persons indefinitely without a trial.<sup>83</sup> In its Concluding Observation for Ecuador, under the category of “Liberty and security of the person (art. 14)” the Committee expressed concern that:

the State party has not taken action to guarantee due process for persons with disabilities accused of having committed an offence. It is also concerned that declaring persons with disabilities unfit to stand trial is a pretext for applying security measures involving their indefinite deprivation of liberty and that they are not entitled to the same guarantees as other persons in the criminal justice system.<sup>84</sup>

The Committee then recommended that Ecuador:

[r]efrain from declaring persons with disabilities unfit to stand trial when they are accused of an offence so that they are entitled to due process, on an equal basis with others, and that the general guarantees of criminal law and procedure are observed.<sup>85</sup>

Whilst the recommendation appears to require the abolition of unfitness to stand trial declarations, when placed in context and when other Concluding Observations are considered, the comments are ambiguous. Concluding Observations to other countries which still use fitness to plead procedures, such as the United Kingdom, do not contain any discussion on the subject.<sup>86</sup> Therefore, it is possible that either there was something particular about Ecuador’s process that attracted the Committee’s attention, or the Committee is not being consistent in its approach to the matter. The Concluding Observations do not provide any detail on the specifics of the law in Ecuador, and all earlier reports such as the List of Issues do not refer to the issue at all.

Furthermore, it seems unlikely that the CRPD was intended to impose an absolute prohibition on persons being declared unfit to stand trial. There will obviously be some extreme cases (for example, comatose patients) where it is difficult to see how refusing to try such a person would be in violation of the CRPD. In its decision in *Noble*, the Committee emphasised that the support and accommodation given to a person should facilitate their effective participation in the trial. This is the same standard that is required under the ECHR. It seemed as if the Committee was acknowledging in *Noble* that there will be some circumstances when support cannot achieve effective participation, and other measures may then be permissible. It is worth keeping in mind that the CRPD only requires the State to give reasonable support and accommodations. Thus, providing that the accused is assessed for what supports are required and that any support that is proportionate and not unduly burdensome is provided, it seems the State will be compliant. The Guidelines on Article 14 indicate that the Committee’s real issue is the potentially indefinite detention without a trial, and that a person is deprived of the opportunity to clear their name, potentially impacting on their right to access justice on an equal basis with other defendants.

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<sup>83</sup> Gooding *et al* (n 81) 844.

<sup>84</sup> Ecuador Concluding Observation (n 82) [28].

<sup>85</sup> *ibid* at [29(b)].

<sup>86</sup> Committee on the Rights of Persons with Disabilities ‘Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland’ (2017) UN Doc CRPD/C/GBR/CO/1.

#### IV. RECOMMENDATIONS FOR REFORM

In the previous section, it was identified that the fitness to be tried procedure contravened Article 12 of the CRPD by removing an accused's legal capacity on the basis of a mental disorder when an accused is declared unfit to be tried. This approach fails to respect the voices of persons with disabilities and also deprives them of their right to equal enjoyment of legal capacity. It was outlined that Article 12.3 required the abolition of substitute decision-making and directed that it should be replaced by support to enable a person to express their will and preferences. Where it was not possible to identify a person's will and preferences, a facilitated decision-maker should make a determination based on the best interpretation of that person's will and preferences that can be formulated.

However, it was identified that support for the exercise of legal capacity must help the accused to participate effectively in their trial, otherwise it will contravene the accused's right to a fair trial under the Irish Constitution and the ECHR. In these circumstances the right to a fair trial must take priority over the right to legal capacity and the respect for the diversity and voice of the accused. Additionally, it needs to be emphasised that the State is only under an obligation to provide reasonable support.<sup>87</sup> Support which would impose a disproportionate or undue burden on the State is not required. Where reasonable support will not guarantee that the accused can participate effectively in the trial, the accused should still be given the opportunity to test the evidence and clear their name. Although this procedure does not result in complete equality, it is as protective of the right of equal access to justice as possible.

In addition to the changes required to the fitness to be tried procedure itself, reform is also needed in the areas of involuntary detention and treatment that might be ordered when a person is subjected to an unfitness declaration. For example, whilst a court directing an accused to involuntarily undergo treatment may eventually help them stand trial, this is not permissible under Article 12 as this alone does not provide justification for the deprivation of legal capacity. Treatment should only be ordered by a court where it is consistent with the accused's will and preferences, or the best interpretation of their will and preferences that is possible. If it is not possible to provide such an interpretation, a best interests principle can be used to make decisions until it is possible to determine that person's will and preferences.

##### *A. Determining the Support Required*

The first step in reform is to redefine the focus and standard of the legal test regarding if an accused should be found unfit to stand trial. Rather than being used as a tool to exclude a person from standing trial, the assessment should be used to determine

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<sup>87</sup> It should be noted that Article 13 requires the "provision of procedural and age-appropriate accommodations". However, Article 5 seems to indicate that only reasonable accommodation is required. Reasonable accommodation is defined in Article 2 as "mean[ing] necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms".

what supports are required to ensure that the trial is fair and the accused can participate effectively. This reflects the paradigm shift endorsed by disability studies where the focus is put on removing obstacles and providing support, rather than depriving the accused of their right to legal capacity. The difficulty is that there are very few studies on how support in the exercise of legal capacity would work in the context of a defendant participating in a criminal trial.<sup>88</sup>

The Law Commission in England and Wales (Law Commission) determined that the test<sup>89</sup> in that jurisdiction was too narrow and recommended that it be widened.<sup>90</sup> It found that there was a disproportionate emphasis on a person's intellectual abilities rather than the other aspects of mental disorders which might affect the defendant's ability to make rational decisions.<sup>91</sup> As a result, it recommended introducing a test which considered capacity for effective participation, including an assessment of the defendant's decision-making ability, often referred to as a 'functional' assessment.<sup>92</sup> It also recommended a separate test of capacity for assessing an accused who wished to plead guilty.<sup>93</sup>

The Law Commission acknowledged that its approach may violate a literal reading of the CRPD.<sup>94</sup> However, it took the view that the defendant's ECHR rights must be protected as a priority, and that for the few defendants who do not gain or recover capacity, a functional approach would not necessarily violate the CRPD because of additional safeguards and an expressed desire to respect the "defendant's rights, will and preferences" where possible.<sup>95</sup> Widening both the statutory and common law test to include a consideration of rational decision-making, along with the traditional requirements of an ability to communicate and having a sufficient intellect or awareness to understand the proceedings, has the potential to improve the fairness of the trial process for persons who have impaired decision-making ability and result in more effective participation. However, the challenge is how to reconcile the Law Commission's approach with a respect for legal capacity, as some academics have questioned whether it is compliant with the CRPD.

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<sup>88</sup> A 2023 support program trialled placing a number of support persons in community legal centres; Piers Gooding, Bernadette McSherry & Anna Arstein-Kerslake, 'Supported Decision-Making in Criminal Proceedings: A Sociolegal Empirical Study' (2023) 34(1) J Disabil Policy Stud 28. Whilst the authors note a number of limitations including small sample size and a limited duration of the support, the study provides promising evidence that formal supports can reduce the number of unfitness to be tried declarations.

<sup>89</sup> The *Pritchard* test requires the accused to be able to understand the charges, decide whether to plead guilty or not, challenge jurors, instruct lawyers, follow the proceedings, and give evidence in own defence; *R v Pritchard* (1836) 7 C & P 303, 304; This test is likely to still represent the law in Ireland when the unfitness does not arise because of a mental disorder, as the provisions of the 2006 Act only explicitly cover circumstances where the unfitness is caused by a mental disorder.

<sup>90</sup> Law Commission, *Unfitness to Plead, Volume 1: Report* (Law Com No 364, 2016) [2.5] <https://lawcom.gov.uk/project/unfitness-to-plead/>.

<sup>91</sup> *ibid* at [2.6]-[2.8].

<sup>92</sup> *ibid* [3.121].

<sup>93</sup> *ibid* [3.155]-[3.156].

<sup>94</sup> *ibid* [3.163]-[3.164].

<sup>95</sup> *ibid* [3.165].

Flynn and Arstein-Kerslake argue that such provisions, even if worded neutrally, will have a disproportionate impact on persons with psychosocial disabilities, as they are the group most likely to be found to have impaired decision-making.<sup>96</sup> Gooding and O'Mahony argue that the Committee has concluded that any mental capacity testing is prohibited outright, as it denies a core human right (equal recognition) if the assessment is failed.<sup>97</sup> These observations are correct. However, functional capacity assessments which are not used for justifying a deprivation of legal capacity may not necessarily violate the CRPD. If the assessments are used only to identify what support is required for the person to have effective participation in their own trial, there is no reason why this change in the legal test would not be an improvement. The current statutory test's focus on communication and understanding excludes persons who may require decision-making support from its scope. By identifying defects in mental capacity, these persons can be provided with support that they previously would not have had access to. This is a similar approach to that recommended by Bach and Kerzner, who argue that the crux of the CRPD issue is "ensuring that individuals are exercising their capacity through the most appropriate status", either independently or with support.<sup>98</sup>

Flynn and Arstein-Kerslake express a fear that such assessments may become status contingent, in that persons with disabilities will have to demonstrate rational decision-making in order to have their decisions legally recognised.<sup>99</sup> They argue that despite the approach being considered as a more just determination of capacity by focusing on behaviour rather than the disability itself, it has the result of holding persons with disabilities to a higher standard than other defendants.<sup>100</sup> However, this fear does not provide sufficient justification for ruling out this approach. The CRPD acknowledges that persons with defects in mental capacity should be provided with support to exercise legal capacity. We can only provide this support by assessing a person's mental capacity in the first place.

Similarly, Gooding and O'Mahony comment that a functional approach to determining fitness to be tried will result in a greater number of defendants with disabilities being stripped of their legal capacity.<sup>101</sup> As acknowledged above, this is a valid concern. However, this can be avoided by ensuring that the focus of the process is changed. Rather than viewing the procedure as a method for excluding 'incompetent' defendants from standing trial, it should be regarded as a means for improving the fairness of the trial and ensuring that persons with disabilities have the same access to justice as everybody else. Thus, the criteria are used to determine the various

<sup>96</sup> Eilionoir Flynn & Anna Arstein-Kerslake, 'Legislating personhood: realizing the right to support in exercising legal capacity' (2014) 10 Int J Law Context 81, 87 <https://doi.org/10.1017/S1744552313000384>.

<sup>97</sup> Piers Gooding & Charles O'Mahony, 'Laws on unfitness to stand trial and the UN Convention on the Rights of Persons with Disabilities: Comparing reform in England, Wales, Northern Ireland and Australia' (2016) 44 Int J Law Crime Justice 122, 136 <https://doi.org/10.1016/j.ijlcj.2015.07.002>.

<sup>98</sup> Michael Bach & Lana Kerzner, 'A New Paradigm for Protecting Autonomy and the Right to Legal Capacity' (2010) <<https://www.lco-cdo.org/wp-content/uploads/2010/11/disabilities-commissioned-paper-bach-kerzner.pdf>> accessed 3 July 2025, 98-100.

<sup>99</sup> Flynn & Arstein-Kerslake (n 96) 88-89.

<sup>100</sup> *ibid* 87.

<sup>101</sup> Gooding & O'Mahony (n 97) 138.

supports that a person will need, not to determine whether they should be found unfit to be tried. It may well be the case that once support is provided, an accused may disagree with advice they have been given and make an unwise decision. Providing that the support has been effective in making sure that they understand their various choices (and the consequences of those choices), it should be their will and preferences that will prevail.

Considering the above, it is suggested that the Law Commission's approach of combining the ECHR effective participation test with an additional consideration of rational decision-making ability is the optimum standard to apply as a starting point, in the absence of empirical research. When more data is available on supported decision-making, there may be a need to revisit and revise this approach. Instead of using the Law Commission's criteria for exclusion, it will be used to evaluate what supports need to be provided.

The purpose of this new evaluation is to remove the discriminatory approach that is occasionally evident in Irish law against persons with a mental disorder. In *People (DPP) v Harrison*, a trial judge finding that the accused was unfit to be tried was overturned.<sup>102</sup> During the original hearing, the psychiatric evidence established that the stress of a trial might put an "extra demand or cognitive load" onto the accused, resulting in their condition causing greater difficulties than it ordinarily would, particularly in recalling details.<sup>103</sup> Dr Monks of the Central Mental Hospital testified that notwithstanding these difficulties, "accommodations could be made" to assist the accused in the event that he was found fit to stand trial.<sup>104</sup> The Circuit Court judge held that such accommodations were an impossibility as:

the Court cannot assess specifically what can be put in place. It's a matter that would evolve over time during the process of the trial and it appears difficult to be able to anticipate what structures could possibly be put in place or to anticipate the difficulties that would be encountered on a day-to-day basis by the accused in respect of the conduct of the trial as the evidence evolved.<sup>105</sup>

The Court of Appeal held that this was an error in principle. The ruling that the accused could not receive a fair trial was premature and the issue of unfitness should not have been confused with the practical accommodations that might have to be introduced to protect the accused's right to a fair trial.<sup>106</sup> The Court also stated that:

[a] question raised as to a person's fitness to be tried in principle must be considered and determined separately and discretely from any issue as to whether a person, having been found fit to be tried in principle, can in fact receive a fair trial in light of particular personal, mental or physical difficulties.<sup>107</sup>

The Court of Appeal's reasoning was not entirely clear. It discussed the accommodation of other difficulties, such as deaf defendants who may require sign

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<sup>102</sup> *Harrison* (n 2) (Edwards J).

<sup>103</sup> *ibid* [34].

<sup>104</sup> *ibid*.

<sup>105</sup> *ibid* [35].

<sup>106</sup> *ibid* [53].

<sup>107</sup> *ibid*.

language, blind defendants who may require documents in Braille, and non-English speaking defendants who might require an interpreter. These accommodations may be essential in ensuring a fair trial in a broad sense, but the affected person would be found unfit to be tried if they were not provided. Thus, there seems to be a difference in approach. When we consider the issue of a deaf person, our instinct is not to question whether such a person is unfit to be tried, but rather to consider what support may be required during the trial. There is no reason why our approach to a person with a mental disorder should be different. A deaf defendant may struggle to understand the evidence presented without assistance just as a defendant with a mental disorder might, but if reasonable assistance or accommodation can resolve this issue for both persons, there seems to be no logical reason why only one should be declared unfit to stand trial merely because of how that difficulty arises. Therefore, the Court's direction that the two issues should be considered separately and discretely is unhelpful. Whether the defendant's particular difficulty can be resolved by assistance or accommodation is surely relevant to whether it is appropriate to declare them unfit to be tried. Thus, whilst the judgment produced the correct result, it still appears to be treating psychiatric difficulties differently from other difficulties, which is contrary to Article 5.4 of the CRPD, which permits differential treatment only when the result is equal enjoyment of a human right.

Therefore, the first step to this issue should always be an evaluation of what support is required to ensure a fair trial. This evaluation should be carried out with the presumption that the accused will be able to stand trial with the appropriate support and accommodation. Only if it is determined that no support can be provided to ensure effective participation should we consider if the trial should be prohibited from proceeding.

### *B. Steps If Support Will Not Result in a Fair Trial*

It is inevitable that there will be some defendants for whom support or accommodations would be inadequate to ensure a fair trial. In this section, it will be considered what provisions should be introduced into Irish law to deal with this issue.

There are some academics who have argued that unfitness to be tried declarations will not be CRPD compliant under any circumstances. Minkowitz argues that the CRPD requires the abolition of all determinations that a defendant is unfit to stand trial, interpreting the provisions of Article 12 (The right to equal treatment) and Article 13 (Access to Justice) to imply that persons with disabilities must be recognised as having the capacity to stand trial for a criminal offence.<sup>108</sup> She argues that procedural accommodations and support can be provided for all stages of criminal proceeding to accomplish this.<sup>109</sup> She further contends that the obligation to abolish such procedures also derives from Articles 13 and 14, as a result of the right to equality in proceedings relating to the deprivation of liberty.<sup>110</sup> The latter argument assumes incorrectly that

<sup>108</sup> Tina Minkowitz, 'Rethinking criminal responsibility from a critical disability perspective: The abolition of insanity/incapacity acquittals and unfitness to plead, and beyond' (2014) 23 Griffith L Rev 434, 444-445 <https://doi-org.ucc.idm.oclc.org/10.1080/10383441.2014.1013177>.

<sup>109</sup> *ibid* 458.

<sup>110</sup> *ibid* 447.



an unfit declaration and involuntary detention are inextricably linked, which is not the case. The former point seems relatively uncontroversial; if a defendant would be deemed fit to be tried only if support was provided, that support should be provided rather than declaring them unfit to stand trial. However, what is not acknowledged in her analysis is that support cannot remedy every risk of an unfair trial.<sup>111</sup> For example, there may be exceptional cases where patients with dementia are unable to retain any new information or recall facts that are vital to their defence. Therefore, there will be occasions when support mechanisms cannot result in effective participation. Rather than insisting that support will always be effective, there needs to be some provisions which can guide courts in those exceptional cases.

Dhanda argues that whilst Article 12 does not prohibit substitute decision-making in its text, when the CRPD is read in light of the treaty's object and purpose, the shift towards supported decision-making is obvious.<sup>112</sup> The solution, where a person's will and preferences cannot be determined, is to decide any matters according to the best interpretation of will and preferences that can be formulated. As discussed in section 3.3, it would be extremely difficult to apply this standard to a defendant participating in a criminal trial. Even if it was possible, it would likely not be sufficient to ensure a fair trial which requires effective participation throughout, not just a prediction of what the defendant might decide on a particular matter.

There may be other difficulties, depending on the particular decision. For example, even if the supported decision-maker, attempting to determine a defendant's will and preferences, is convinced that it would be their desire to plead guilty, it is difficult to believe that the courts could ever permit a guilty plea to be made based on such a belief. They could not be satisfied that the defendant understands the legal consequences of making such a plea. Even if we can determine a defendant's preference in some matters, such as that an incapacitated person would have chosen to testify in their own defence, it may be of limited practical use if the person is incapable of providing this testimony. Furthermore, an accused's role in their own defence is not limited to making decisions. Often it is their own knowledge of the events that is essential to their defence, which is why an emphasis is placed on the ability to instruct a legal representative. If this knowledge cannot be communicated, then there is a risk of injustice and an unfair trial.

Thus, it is acknowledged that there will be some occasions when it will not be possible to ensure that a defendant can have a fair trial. However, some additional safeguards are required to ensure that the defendant is not prematurely or unnecessarily excluded from the trial process.

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<sup>111</sup> Jill Peay, 'Mental incapacity and criminal liability: Redrawing the fault lines?' (2015) 40 Int J Law Psychiatry 25, 29 <https://doi.org/10.1016/j.ijlp.2015.04.007>.

<sup>112</sup> Amita Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2007) 34 Syracuse J Int'l L & Com 429, 460-462 <https://www.proquest.com/scholarly-journals/legal-capacity-disability-rights-convention/docview/197142449/se-2>.

Studies have shown different psychiatrist and psychologist findings regarding fitness evaluations in a number of hypothetical cases.<sup>113</sup> The Interdepartmental Group, which was set up to examine issues relating to people with mental illness who come in contact with the criminal justice system, recommended the introduction of an obligation on the part of the trial judge to consider medical evidence before making an unfitness to be tried declaration.<sup>114</sup> This is currently optional under the 2006 Act. Whilst making the consideration of medical evidence mandatory is a step in the right direction, this recommendation does not alleviate the concern of unreliable assessments. In its 2016 report, the Law Commission recommended that a second medical report should be required to aid in filtering out “rogue reports”.<sup>115</sup> This approach is preferable to the single report recommendation of the Interdepartmental Group.

The reports should aid the court in determining the defendant’s prognosis. If there is a reasonable chance that the defendant may recover to the extent necessary to stand trial with appropriate supports in a reasonable amount of time, then the hearing should be adjourned without a declaration that the accused is unfit. What constitutes a ‘reasonable’ amount of time is difficult to ascertain in the absence of research, but for the purposes of this article, it will be set at six weeks.<sup>116</sup> If it is determined that the accused is not likely to recover within six weeks, the court will need to decide between three possible courses of action.

*(i) where there is a reasonable chance that the defendant’s condition will improve to the extent necessary to participate effectively in a trial, but not within a reasonable amount of time.*

There may be some cases where there is a reasonable chance that the defendant will recover, but not within a short period of time. In this case, the State’s responsibility will be to assist the defendant to getting to a place where their cognition and decision-making skill will be at a point where they can be supported to stand trial. An unfitness declaration should still not be issued, but it will be necessary for the court to order treatment as part of the support and accommodation measures that are necessary.

Treatment can be ordered, providing there are no indications that it would be against the true will and preferences of the defendant, and should be recommended by the same two approved medical officers who have determined that the accused is currently unable to receive a fair trial. This treatment can be based on the assumption in Saks model<sup>117</sup> that when a mental disorder has deprived a person of their ability to

<sup>113</sup> Grant H Morris, Ansar M Haroun & David Naimark, ‘Competency to Stand Trial on Trial’ (2004) 4 Hous J Health L & Pol’y 193, 214 <https://heinonline.org/HOL/P?h=hein.journals/hhpol4&i=203>.

<sup>114</sup> Department of Justice and Equality, *First Interim Report of the Interdepartmental Group to examine issues relating to people with mental illness who come in contact with the criminal justice system* (Department of Justice and Equality 2016) 21.

<sup>115</sup> Law Com 364 (n 90) 113.

<sup>116</sup> This time period was chosen because it may be up to six weeks before some patients feel the “full effect” of antipsychotic medication; National Institute of Mental Health, ‘Mental Health Medications’ <<https://www.nimh.nih.gov/health/topics/mental-health-medications>> accessed 3 July 2025.

<sup>117</sup> Elyn Saks, ‘Refusing Care: Forced Treatment and the Use of Psychiatric Advance Directives’ (2004) 4(4) J Forensic Psychol Res Pract 35, 38 [https://doi-org.ucc.idm.oclc.org/10.1300/J158v04n04\\_03](https://doi-org.ucc.idm.oclc.org/10.1300/J158v04n04_03).

communicate or make decisions, a person would typically opt for assistance in returning to a state when they are able to communicate their will and preferences.<sup>118</sup> Treatment and care may be ordered on an outpatient basis, although dependant on the defendant's own circumstances, it may be necessary to detain them in the Central Mental Hospital for the purposes of this treatment. If detention is essential, additional safeguards will be required. Those detained for treatment under this process should receive a review of detention and progress every 28 days, although an additional review can be requested by the patient or their legal representatives. An appropriate length of time needs to be set by the medical officers by which the defendant would normally have been expected to start recovery.<sup>119</sup> This will vary according to the condition but is necessary to ensure that the restriction of liberty is proportionate to the goal of helping the defendant communicate their will and preferences.

Available data suggests that recovery was most common in patients with schizophrenia or related conditions and occurred within 18 months.<sup>120</sup> Thus, 18 months seems to be the most reasonable estimate that can be formulated at this time. This process may create a tension with the accused's right to a speedy trial, guaranteed by both the ECHR<sup>121</sup> and the Constitution,<sup>122</sup> but on balance it seems to be a proportionate limitation. Rather than depriving the accused of the right to stand trial and subjecting them to a determination of 'unfitness', it should be recognised that justice may sometimes be better served by delaying the trial and allowing the accused to recover before presenting their defence.

If, at any point, it becomes apparent that treatment is against the true will and preferences of the defendant or that the defendant is not likely to recover within a reasonable period of time, the process must be discontinued and either of the procedures outlined in (ii) or (iii) below should be followed, as appropriate. This approach ensures that the voices of persons with disabilities are respected but also ensures that the State is able to assist the accused in recovering to the extent that they can have an equal access to justice.

*(ii) where there is no reasonable prospect that the defendant's condition will improve to the extent necessary to participate effectively in a trial.*

As psychiatry is uncertain and inexact, a "reasonable certainty" test has been suggested rather than absolute certainty that the accused will never regain the capacity to stand trial.<sup>123</sup> It seems futile to leave charges pending, or to keep the defendant detained if there is no reasonable prospect that they will ever be able to stand trial.

<sup>118</sup> On this point, see Flynn & Arstein-Kerslake who argue that: "the social contract provides the framework within which we can presume that no individual prefers to be harmed, and where someone is being harmed she would like assistance in ending the harm"; Flynn & Arstein-Kerslake (n 96) 99.

<sup>119</sup> Eizenstat (n 50) 406.

<sup>120</sup> Luke Noonan, 'Reforming Mental Condition Defences and Procedures in the Criminal Justice System in light of the Convention on the Rights of Persons with Disabilities' (PhD thesis, University College Cork 2023), Appendix 9 <https://hdl.handle.net/10468/15552>.

<sup>121</sup> ECHR (n 10) Article 6.

<sup>122</sup> *State (O'Connell) v Fawsitt* [1986] IR 362, 371 (Murphy J).

<sup>123</sup> Eizenstat (n 50) 405.

This may particularly be the case where the defendant has a severe intellectual disability or a condition like dementia which will only worsen over time. In Ireland, it appears that such defendants are not usually subjected to a committal order if treatment will not help their conditions.

However, at this stage the question becomes whether we should proceed to a trial in light of the defendant's condition. Does an incapacitated defendant have the right to test the charges against them? Delaying the trial further will not improve matters. Either the charges are dropped or the trial proceeds. The CRPD indicates that the latter option is preferable, whilst the ECHR would seem to prohibit such an approach. Arstein-Kerslake *et al* suggest that in these "hard cases", the accused should be provided with an advocate who has the "responsibility for interpreting the will and preference of the individual to the best of that person's ability and to convey that to the court and the relevant professionals involved with the trial process".<sup>124</sup> They do not discuss any specific functions that this advocate could perform. Whilst it is acknowledged that an advocate could play a role distinct from a legal advisor, it was discussed above that there are limitations as to the utility of the best interpretations of a defendant's will and preferences in a criminal trial. It may help to ensure that the defendant's preferences are respected by their legal representation, but it is unlikely that it would result in a fair trial, where justice may depend on knowledge that is only known to the defendant.

As outlined in section 2.1, the Irish legislation provides for a hearing to be held to determine if reasonable doubt exists as to the accused's guilt after they have been found unfit to be tried, although such a procedure is not mandatory, and it is unclear how often it occurs in practice. The Interdepartmental Group has recommended that this optional 'trial of the facts' procedure should be mandatory before any committal order is made.<sup>125</sup> To comply with the CRPD, it seems that any such opportunity for a defendant to clear their name must be mandatory, especially in circumstances where it is likely that they will never recover to the extent that they will be able to stand trial. In this case, rather than being a criminal trial, the process would be an 'without prejudice' hearing into the alleged incident. The hearing would resemble an actual criminal trial in all respects except one. There are no consequences for the accused if they are not acquitted; it is an opportunity for them to test the evidence and clear their name, it does not result in a conviction if the prosecution is able to prove their case beyond reasonable doubt. In this 'without prejudice' hearing, the accused's legal representatives would be able to argue any defence that would normally be admissible at a trial, and the prosecution would have to prove all the elements of the offence, including *mens rea*, beyond reasonable doubt.<sup>126</sup>

Arstein-Kerslake *et al* are doubtful that this separate adjudication process meets CRPD standards as it still deprives persons with disabilities of the full trial that other

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<sup>124</sup> Anna Arstein-Kerslake, Piers Gooding, Louis Andrews & Bernadette McSherry, 'Human Rights and Unfitness to Plead: The Demands of the Convention on the Rights of Persons with Disabilities' (2017) 17 HRLR 399, 414 <https://doi-org.ucc.idm.oclc.org/10.1093/hrlr/ngx025>.

<sup>125</sup> First Interim Report (n 114) 22.

<sup>126</sup> See further, Gooding *et al* (n 81) 847.

defendants receive, and thus is still discriminatory.<sup>127</sup> However, there is no way that a fair trial can be conducted without effective participation from the defendant and thus, any attempts to impose a criminal sanction in this hearing would be in violation of both the Constitution and the ECHR. Gooding *et al* are more optimistic about alternative trial processes, believing that such may be acceptable under the CRPD if the same standard of proof is used as in typical criminal trials, the accused continues to be presumed innocent, and all defences are available.<sup>128</sup>

It seems that double jeopardy will not attach if the accused is cleared at the hearing. If the accused is not in jeopardy to begin with, the prosecution cannot be prevented from trying the accused again. Therefore, a specific statutory provision would also be required to establish that an accused who is acquitted at the 'without prejudice' hearing cannot be subjected to a subsequent criminal trial in relation to the same incident if they were to regain capacity.

Where the result of the 'without prejudice' hearing is that the prosecution has proven all the elements of the offence, the reporting restrictions contained in the 2006 Act should apply to this result. This is necessary to protect the accused's right to a good name. In this regard, it is important to bear in mind the point of the hearing. It gives the incapacitated person the right to test the evidence and clear their name, but it is not enough to actually prove their guilt. This goal is not possible unless the accused is in a position to assist in their own defence.

Where an accused is acquitted, the situation is more complicated. It seems as if it might be necessary to extend the reporting restrictions to cover acquittals. This is because of the new mandatory nature of the 'without prejudice' hearing. If the media could report acquittals, then silence on the result would indicate that the accused had not been acquitted at this hearing. However, this seems to deprive the accused of their right to clear their name in public. One solution is to prevent the media from publishing an accused's details if there is a fitness to be tried issue and only permit the accused's identity to be revealed if they are cleared at the 'without prejudice' hearing or are subsequently found fit to be tried.

Where the 'without prejudice' hearing has failed to exonerate the accused, they should be discharged unless "because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other person".<sup>129</sup> The position of this article is that the CRPD does not prohibit involuntary detention in such cases. In the unlikely event that the accused should recover to such an extent that they are able to stand trial, an actual criminal trial should take place, subject to the standard safeguards regarding the prejudice that delay may cause an accused's defence.

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<sup>127</sup> Arstein-Kerslake *et al* (n 124) 415.

<sup>128</sup> Gooding *et al* (n 81) 863.

<sup>129</sup> This is currently the first ground contained in the Mental Health Act 2001 which permits involuntary detention; Mental Health Act 2001, s 3(1)(a).

(iii) where there is a reasonable prospect that the defendant's condition will improve to the extent necessary to participate effectively in a trial, but treatment is contrary to the defendant's true will and preferences.

Determining a defendant's true will and preference can be challenging when they lack insight into their condition, but generally the CRPD prohibits forced treatment unless there is an immediate risk of death or serious injury. When it is clear that it is the defendant's true will not to undergo treatment, and this is not caused by a lack of insight, then treatment or detention must not be ordered.

At this stage, the process can move to the procedure outlined in (ii) unless it is determined that the defendant's refusal to undergo treatment is a deliberate attempt to frustrate the trial process or avoid being answerable for their crime. If it is the latter, it may be permissible under the ECHR to consider that the defendant has waived their right to be present and participate in their trial, and the criminal process can continue with a trial *in absentia*.<sup>130</sup> To what extent the Irish Constitution would permit such a process is uncertain.<sup>131</sup> In *People (Attorney General) v Messitt*, Kenny J, delivering the judgment for the Court of Criminal Appeal, considered it "unnecessary to attempt to state comprehensively when it is permissible to depart from the rule that the trial of an indictable offence must be conducted in the presence of the accused", and that the court only had to decide whether the absence in the present case invalidated the trial.<sup>132</sup>

However, it is clear that in certain circumstances trials *in absentia* would pass constitutional muster. It could be argued that the policy reasons for not allowing a defendant to deliberately frustrate the trial process by refusing to undergo treatment are just as strong as defendants who voluntarily absent themselves by other means, such as bad behaviour in the courtroom. Certain safeguards will be required, and the discretion must be exercised with "great caution and with close regard to the overall fairness of the proceedings".<sup>133</sup> It will only be appropriate to hold a trial *in absentia* in circumstances when the defendant has been adequately warned and given sufficient notice about the consequences of their deliberate attempts to avoid a trial. The Court must be satisfied the defendant understands this warning. Additionally, the trial should only continue with adequate legal representation for the defence. If the defendant has not appointed their own representation, the Court should do so for the purposes of the trial *in absentia*. It may also be appropriate for the trial judge to provide the jury with special instructions depending on the nature of the specific case.<sup>134</sup> If the result of the trial *in absentia* is a conviction, the defendant should be provided with an option of a trial *de novo* if they now wish to participate in the proceedings.

<sup>130</sup> *Colozza v Italy* App No 9024/80 (ECHR, 12 February 1985) [28]-[29]; *Sanader v Croatia* App No 66408/12 (ECHR, 12 February 2015) [77]-[78].

<sup>131</sup> Michael Forde & David Leonard, *Constitutional Law of Ireland* (3rd edn, Bloomsbury 2013) [17.22].

<sup>132</sup> *People (Attorney General) v Messitt* [1972] IR 204, 211 (Kenny J).

<sup>133</sup> O'Malley (n 63) [4-58].

<sup>134</sup> *ibid* [4-59].

## V. CONCLUSION

Arstein-Kerslake *et al* argue that:

[i]nstead of seeing inconsistencies ... as an insurmountable barrier, [the innovations of the CRPD should be used as a lens to] ... examine the status quo and explore whether the antiquated – and sometimes inconsistent – laws of the past sufficiently protect the rights of persons with cognitive disabilities.<sup>135</sup>

When examining the fitness to be tried procedure under the lens of the CRPD, it can be seen that the process often discriminates unfairly against persons with disabilities and deprives them of their legal capacity without appropriate safeguards. However, any reform needs to comply with the constitutional right to a fair trial and the ECHR requirement of effective participation on the part of the defendant.

To achieve an appropriate balance, it has first been suggested that the legal test for unfitness should be widened to include an assessment of decision-making capacity. This new legal test should not be used to assess fitness to stand trial, but to determine what supports or accommodations are necessary for the accused to participate effectively in the trial.

There may be hard cases, where no amount of support will be sufficient to satisfy ECHR or constitutional requirements. In this situation, an assessment should be made by at least two medical practitioners as to whether the accused is ever likely to be able to stand trial with support. If there is no reasonable chance at recovery, the matter should proceed to a 'without prejudice' hearing so the evidence against the accused can be tested, and their legal representatives can present a defence and attempt to clear their name. If there is a reasonable chance of recovery within a short period of time, the trial should be postponed. At this point, efforts should focus on "augmenting [the accused's] decision-making ability to a point at which [they] can clearly express [their] wills and preferences", communicate their decisions, and adequately understand and follow the trial process.<sup>136</sup>

Whilst this article has suggested a procedure which strikes a balance between CRPD compliance and the rights to a fair trial, there are limits to what can be achieved by a doctrinal methodology. Reform in this area should be paused until there has been sufficient research conducted into supported decision-making, particularly by the disciplines of psychiatry and psychology, and how it would work in the context of a criminal trial. This article provides a legal framework that can act as a basis for future research for these disciplines.

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<sup>135</sup> Arstein-Kerslake *et al* (n 124) 418.

<sup>136</sup> Flynn & Arstein-Kerslake (n 96) 98.